REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

AN EVALUATION OF THE MEDI-CAL PROGRAM'S SYSTEM FOR ESTABLISHING REIMBURSEMENT RATES FOR NURSING HOMES

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Telephone:
(916) 445-0255

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

Thomas W. Hayes
Auditor General

October 28, 1987 P-646

Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents a report prepared under contract by Lewin and Associates, Incorporated, concerning the State's Medi-Cal rate reimbursement system for long-term care for the State's elderly.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

AN EVALUATION OF THE MEDI-CAL PROGRAM'S SYSTEM FOR ESTABLISHING REIMBURSEMENT RATES FOR NURSING HOMES

SUBMITTED TO

THE OFFICE OF THE AUDITOR GENERAL THE STATE OF CALIFORNIA

PREPARED BY

LEWIN AND ASSOCIATES, INC.

WITH

GEORGETOWN POLICY ASSOCIATES, INC.
LINCOURT & ASSOCIATES, INC.

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Lewin and Associates incorporated

OUTLINE OF FINAL REPORT

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EXECUTIVE SUMMARY

California could better achieve its major objectives of ensuring adequate access to high quality nursing home care for Medi-Cal patients within a cost controlled system by implementing a prospective facility specific reimbursement system that differentiates between patient care related expenditures and other costs of operation. Such a system can balance quality of care and efficiency objectives by encouraging spending on direct patient care items and not allowing any profit on this cost component, while allowing facilities to retain a portion of savings that result from efficient operations on the other elements of operations. By adjusting the ceiling on the reimbursement of the direct patient care expenditures and the extent of the efficiency incentive on other expenditures, the system can be designed to achieve any specified level of total expenditures, e.g. such a system can be established within a budget neutral constraint.

Advantages of a Facility Specific Cost Component System Over the Current Flat Rate System

The current flat rate system pays each facility (within bed size and geographical categories) the same rate no matter how much the particular facility spends, thus maximizing the incentives for the facility to curtail expenditures. In such a system, one cannot discriminate between efficiency in operations and skimping on the quality of patient care. Our review of 1985 cost data from 970 skilled nursing facilities showed that there was an inverse relationship between the amount of profit per patient day and the amount spent on direct patient care items. For example, facilities whose Medi-Cal rate was more than 10 percent above its reported (non-audited) costs spent $24.52 per patient day on patient related activity (nursing, dietary, social services), whereas those whose Medi-Cal rate was between 10 and 25 percent below their reported (non-audited) costs spent $31.01 per patient day.

Solutions to ongoing concerns about the quality of care in California's nursing homes have largely focused on increased enforcement of licensing and certification regulations. The Legislature has attempted to use the reimbursement system to target funds for increased non-administrative hours and/or salaries through a set of labor passthrough measures, some in augmentations and some through specifying the use of cost-of-living adjustments in the budget process. At best, these attempts to target funds for expenditures more directly related to quality of care deal only with the dollars being added to the base rate and do not approach the issue of the discrepancies in expenditures among facilities in these base amounts. These labor passthrough measures have been costly and complex to administer. The first round of audits on the SB 53/AB 180 (1985) labor passthrough requirements, for example, required almost as much auditor time as the regular rate audit of the entire facility's cost report and revealed an amount of unspent dollars subject to recoupment of 11-12 percent of the appropriation.

The difficulties in implementing the labor passthrough are reflective of trying to target funds to achieve a quality of care objective within a flat rate system that has no mechanisms for accountability at the facility level. We believe the principle behind the labor passthrough is correct and appropriate, i.e. that more funds spent on direct patient care activity will enhance the quality of care, but the administrative mechanisms to accomplish this end are not easily integrated into a flat rate system.

By adopting a facility specific rate that establishes a rate for the direct patient care cost component based on what a facility has actually spent, the state can both encourage spending on these quality care related items and ensure greater accountability for how its funds are used.

A major advantage of the flat rate system is its ability to contain costs by allowing facilities to keep any funds they do not spend, thus

reducing the cost base for the subsequent year's rate. But even this benefit has been compromised in the last few years. Again, because of the inability to target funds within the base of the rate under the current system, the Legislature has used augmentations to target spending on non-administrative labor and, as a consequence, the total Medi-Cal expenditures on nursing home care have grown more rapidly than in earlier years.

The facility specific rate system we recommend can be designed to control cost escalation. Rebasing the rate system every three years instead of every year will reduce the inflationary aspects of the system. And, as indicated above, the parameters of the system can be designed to allow for a budget neutral constraint.

Special Provisions Need to be Made for Medi-Cal Patients with Heavy Care Needs

Our study reconfirmed the finding of others that Medi-Cal patients with heavy care needs have difficulty in obtaining access to nursing home care. Because the current flat rate system pays the same rate no matter what level of care a patient needs, there is a financial disincentive to accept a patient who will require extensive care. We also believe there are serious potential quality of care concerns where the cost of adequate care for a particular patient population exceeds the rate paid.

A new subacute category for Medi-Cal patients has recently been instituted to accommodate patients who no longer require acute hospital care but whose special nursing needs exceed what is available in a skilled nursing facility. This category has been so narrowly defined by the Department of Health Services that less than one-half of one percent of Medi-Cal patients in nursing homes fit the requirements. We estimate from our Resident Assessment Study that from 8 to 12 percent of the Medi-Cal population may have care needs that are so extensive that they experience impediments in access to care and potentially inadequate care at the rates currently paid.

We recommend that a Special Care Class with a supplemental rate be established for these patients. The same type of administrative structure as currently used with the subacute category could be utilized for patient assessments and frequent on-site reviews of facilities that have contracts to provide this type of care. The patient care component of the facility's rate would be supplemented for each patient in this category served by the facility.

Some of the Disparity Between Hospital Based Distinct Part and Freestanding Facility Rates Cannot Be Justified

Under the current system, hospital based distinct part units are considered a separate class from freestanding skilled nursing facilities. While the state officially recognizes only one level of skilled nursing care, the rates paid to hospital based units are, on average, about three times higher than those paid to freestanding facilities. The recent growth in community hospital distinct part units has raised the level of debate over potential inequities caused by the rate differential.

Our analysis of 1985 SNF cost information confirmed an earlier Office of Statewide Health Planning and Development study which showed that hospital based units provide more nursing hours per patient day and pay higher wages than do freestanding facilities. From our Resident Assessment Study, we were also able to determine that patients in hospital based units have a higher overall level of acuity and receive more special nursing care than do patients in freestanding facilities.

But not all of the difference in costs between hospital based and freestanding units can be accounted for by patient needs, services provided, and wage rates. A substantial remaining portion results from the higher property and indirect expenses associated with providing skilled nursing care

in hospitals. While we believe that hospital based units in fact, on average, provide a level of care above the freestanding facilities that should be recognized by the state, the current rate differential is too wide.

We recommend that investor owned and not-for-profit hospital based units continue to be paid their projected cost per day up to a ceiling, but that this ceiling be placed at the Medicare upper limit rather than the median of the class. Our Resident Assessment Data suggest that Medicare patients in the hospital based units have a higher acuity level than the Medi-Cal patients, so we can see no justification for the state's paying above the Medicare limit.

County-owned hospital based units should continue to be paid their projected costs up to the median of the class. Cost allocation issues that artifically inflate costs in most hospital distinct part units are less of a problem with many of these facilities that have very few acute care beds. Further, the county facilities serve a unique role in many communities, providing care for patients that cannot be placed elsewhere.

Alternatives Considered
but Rejected for the Near Term

Two alternative reimbursement system approaches were examined as specified in the Request for Proposals for the study and, for various reasons, are not being recommended.

While we believe a Special Care Class needs to be established to accommodate the access and quality of care problems of heavy care Medi-Cal patients, we do not recommend that the state adopt a full case mix system for all its patients. Under such a system, rates would be adjusted to match the level of care needs of all the patients in the state's nursing homes.

Our Resident Assessment Study indicated that there was not wide diversity among facilities in their average case mix, thus reducing one of the equity justifications for a case mix system. Further, we sensed a mixed receptivity to the idea of a case mix system during our interviews with parties with an interest in the issue. While some felt such a change was essential, a number of others expressed serious skepticism and reservation. While we believe that many of the concerns are not justified, the climate of doubt would make what would be a monumental undertaking under the best of circumstances even more difficult to implement.

Patient advocate groups urged a careful consideration of a reimbursement system tied to outcomes, so that facilities would receive a higher rate for providing care that resulted in better patient outcomes. While such a system has obvious conceptual appeal, significant definitional and operational complexities and uncertainties make its successful implementation infeasible. The results of a pilot study in San Diego in the early 1980s confirm the view that such an approach would not yield a benefit commensurate with the efforts to establish it. We believe the changes we are recommending will lead to greater spending on direct patient care which thus far is the best demonstrated means for ensuring good patient outcomes.

Implementation of Recommendations Will Require Careful Monitoring

To accomplish the above recommendations, the state will need to make changes in its accounting, reporting, and auditing functions. Under the current flat rate system, obtaining accuracy in cost reports at the facility level has not been necessary for the purposes of establishing rates. As a consequence, attention to these administrative activities has been modest. Desk audits for consistency of classifications performed by the Office of Statewide Health Planning are not used by the Rate Development Section in its determination of facility costs. Annual audits on a 15 percent sample of

facilities routinely find the same amount and type of errors in reporting Medi-Cal allowable costs.

Under the facility specific cost component reimbursement system recommended above, having accurate and consistent cost reports will be absolutely essential. While the administrative effort and costs of achieving this level of accuracy will be greater than at present, it is not beyond the technical capacity of the state to accomplish nor is it more than most other states already do. Given the approximately $1 billion budget for nursing home care, the relatively modest increases in administrative costs to ensure a more accountable system is, in our view, justified.

Monitoring and Development Activity Will Need to Proceed in Conjunction With Implementation of Recommendations

We do not recommend that California immediately adopt a separate reimbursement methodology for the capital-related component of costs because of the complexitiies entailed in doing so. This portion of costs represents only 9 to 10 percent of the average facility's total costs and does not have as immediate an impact on quality of care as does the direct patient care cost component. The state may well choose to split out capital-related costs at some point in the future and the development work that explores alternatives should be begun now.

The information we reviewed suggests a general deterioration in the access to care for Medi-Cal patients. Bed supply has not kept up with the growth in the elderly population in the state, and what growth there has been has been filled by private pay patients. Numerous factors make the predictions of supply and demand for nursing home care difficult. The state needs to rigorously monitor on a routine basis the growth in beds expected within the next few years by tracking projects in the pipeline, and to devise means by which to assess and pinpoint the access problems of Medi-Cal patients.

Comments on the Overall Level of California's Nursing Home Rates

California spends less in its Medicaid program for nursing home care per elderly resident in the state than many other states. This fact by itself is not definitive since it does not account for variations in the state's elderly population (that is younger and healthier on some measures than average) or the extent of residential care and community support services that are available in the state and that provide alternatives to nursing home care.

Based on our analysis of SNF costs in 1985, we estimate that slightly over 50 percent of the state's facilities earn a positive margin on their Medi-Cal patients (i.e., the Medi-Cal rate is higher than their cost per day) as would be expected with a flat rate system that pays at the median of facility costs per day. Because of the concentration of Medi-Cal patients in facilities that have positive margins on Medi-Cal patients, the nursing home industry earns a positive margin on about 68 percent of the Medi-Cal patient days, while the 32 percent balance of the days are subsidized by private payers. There is a wide diversity in profitability with about 17 percent of the facilities having Medi-Cal rates more than 10 percent above their costs per day, and 10 percent of the facilities having Medi-Cal rates more than 10 percent below their costs per patient day.

By implementing the recommendations for a facility specific cost component based system, the state should be able to redirect some of the excess surpluses being earned by facilities to provide some relief to facilities which have negative margins because of higher than average expenditures on direct patient care items. Under this system there will be a better focusing of the dollars spent on promoting the state's quality of care and access goals within whatever overall level the state decides to commit.

CHAPTER I: INTRODUCTION

As of the end of 1986, California had approximately 1,200 freestanding nursing home facilities and 86 hospital-based distinct part nursing home units with a total bed capacity of approximately 118,000. The state has an obligation to ensure that these facilities provide an adequate level and quality of care. The state purchases care through the Medi-Cal program for about 65 percent of the residents of nursing homes and has a particular concern that Medi-Cal recipients in need of nursing home care have reasonable access to such care without placing undue strain on the total Medi-Cal budget. In 1986 the Medi-Cal program expended nearly $1 billion on nursing home care* (about half of this in state General Fund dollars), or about 21 percent of the total Medi-Cal budget.

Two types of nursing home care are reimbursed under the Medi-Cal program. Skilled nursing facilities (SNFs), whether in freestanding or hospital-based units, are designed to care for patients who do not need the full range of health care services provided by a hospital but who do require the continuous availability of skilled nursing care provided by registered nurses and licensed vocational nurses. Intermediate care facilities (ICFs), all located in freestanding facilities, serve patients who do not require continuous professional nursing services but who do need protective and supportive care above the level that can be provided in a residential care facility.

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*Excluding Intermediate Care Facilities for the Developmentally Disabled (ICF-DD and ICF-DD-H) that accounted for another $75 million.

California's Medi-Cal Program Uses a Prospective Flat Rate Reimbursement System

The federal government requires that rates paid to nursing homes by states under the Medicaid program (Medi-Cal in California) be reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur to provide care that is in conformity with appropriate state and federal laws, regulations, and quality and safety standards. States have substantial flexibility under this standard in the designing of rate-setting methodologies.

California has adopted what is termed a "prospective flat rate" system under which facilities receive a predetermined rate per day for each Medi-Cal patient the nursing home serves. (In fact, part of this cost is in some cases the responsibility of the patient under a share of cost or spend down requirement.) The Rate Development Branch within the Department of Health Services is responsible for establishing rates which are then recommended by the Administration to the Legislature. Freestanding facilities are divided into seven SNF classes and seven ICF classes based on facility size and geographical region. Each facility within a particular class receives the same rate as all other facilities in that class so that an individual facility's costs for providing services to Medi-Cal patients does not directly affect the reimbursement it receives.

To determine the rate for each class, the state collects cost information for each facility from reports submitted to the Office of Statewide Health Planning and Development (OSHPD). The department then adjusts these cost reports by a factor that reflects the nonallowable Medi-Cal costs determined by annual field audits on a sample of approximately 15 percent of the facilities. The facility's historical cost per day is then projected forward to the rate year using various inflation indices. The

resulting projected costs per day for each facility within each class are arrayed. The cost per day of the median facility within each class is the rate paid to all facilities in that class for the budget year.

Hospital-based facilities constitute a separate class for the purposes of rate development. Historical costs for these facilities are obtained from the hospitals' Medicare Cost Reports. The audit adjustment factor from the freestanding facility sample audits is applied to the historical costs and then these costs are inflated by the same inflation indices as are used on the freestanding facilities to project costs to the rate year. These projected costs per day for each facility are arrayed and each facility receives the lower of its projected cost per day or the median cost per day of the class.

In constructing the rates, the Rate Development Branch divides the costs into four components: labor (including benefits), property taxes, fixed costs (depreciation, leases and rental, interest, leasehold improvements, and other amortization), and all other costs. These cost components are broken out in order to apply differential inflation factors to the historical costs to project costs forward to the rate year. The division of expenditures into these categories has no other use under the current flat rate system, i.e., facilities have no obligation to spend their basic reimbursement dollars in any particular proportion among these cost categories.

Under the prospective flat rate system there is a strong financial incentive for facilities to operate at low expenditure levels since they receive the same amount no matter how much they actually spend in the budget year and their future rate is not determined by their current level of expenditures. If a facility's cost per day is below its rate it can retain the entire difference between its rate and its costs as profit. If a facility's costs per day are above its rate it can minimize its losses by reducing its expenditures. While this type of reimbursement system encourages

cost control it does not create incentives for facilities to spend funds on patient care-related items that would enhance quality of care.

Quality of Care and Access to Care Concerns Persist

There has been and continues to be significant concern about the quality of care being provided in the state's nursing homes. The Little Hoover Commission in its 1983 Bureaucracy of Care report pointed to deficiencies in the Licensing and Certification process and suggested improvements that should be made. The state monitors facilities through this mechanism to enforce minimum standards specified in law and regulations. The Auditor General in a November 1984 report recommended improvement in the state's citation process. Recommended reforms were incorporated in SB 53/AB 180 in 1985, resulting in more strenuous enforcement activity. The recent May 1987 Little Hoover Commission report, while noting improvement, recommends an additional series of regulatory and enforcement actions to enhance the quality of care within the state's nursing homes.

The Legislature has attempted to address the quality of care issue through the reimbursement system, but because of the inability to target reimbursement for patient care needs under the basic flat rate system it has had to adopt a special mechanism, the labor passthrough, in order to do so. Under the prospective flat rate system there are no requirements for how a facility expends its Medi-Cal funds. The Legislature had particular concerns about the potential negative impact on quality of care resulting from the high turnover of nurse's aides, who provide over 70 percent of the actual hours of direct patient care. Consequently, the Legislature enacted Chapter 19, Statutes of 1978, which augmented Medi-Cal daily rates for all facilities by $2.28 and required that all of this increase be passed on to nonadministrative employees of each facility. This same concept (with modifications) of targeting increases in rates to nonadministrative employee salaries was

revived in the SB 53/AB 180 legislation in 1985 and in 1985, 1986, and 1987 budget language (the last of which was blue pencilled by the Governor).

The Little Hoover Commission has also noted the difficulties that Medi-Cal patients have in obtaining access to nursing home care, some being placed long distances from their home and relatives. Because the flat rate system for reimbursement pays a facility no more for a heavy care patient than one with low or moderate needs, a financial disincentive exists to accept patients who require a high level of care, creating particular access problems for this group. The slow growth in the nursing home bed supply and the decrease in the number of Medi-Cal patient days in nursing homes has heightened worries about the access to care for Medi-Cal patients in general. The state revised its certificate-of-need criteria to allow for more nursing home beds and finally terminated such review entirely as of January 1, 1987.

As part of the focus of attention on the nursing home industry, there has been a growing interest in undertaking a thorough review of the state's Medi-Cal reimbursement system. A number of other states have adopted more sophisticated reimbursement systems that attempt to address quality of care and access issues more directly than may be possible under California's flat rate system. This study, commissioned by the state Auditor General, is an attempt to evaluate the current system and potential alternatives.

SCOPE AND METHODOLOGY

The objective of this study as requested in the Auditor General's Request for Proposals (RFP) is "to examine the existing Medi-Cal long-term care reimbursement system and recommend modifications that will provide high quality care, adequate bed supply, and operational efficiency at nursing homes operating within the State." The Auditor General requested that the contractor develop criteria against which to evaluate the current system and possible alternative approaches. The RFP also specifically directed the

contractor to analyze how the facilities' costs of providing services compared to the rates Medi-Cal pays and to examine characteristics of patients within the state's nursing homes.

Lewin and Associates and its subcontractors, Georgetown Policy Associates and Lincourt and Associates, performed the following tasks during the course of the study:

- Interviews on multiple aspects of the nursing home reimbursement issue with over 30 state officials representing the executive and legislative branches.

- Interviews with all the relevant facility membership associations as well as with a range of current and prospective facility owners and/or administrators to ascertain their perceptions of how the reimbursement system impacts on their operations and decisions.

- Interviews with a range of consumer advocates to determine their views on the problems in California's nursing homes and the potential role that reimbursement can play in ameliorating them.

- Review of all relevant laws and regulations at both the federal and California levels.

- Analysis of the actual costs of 970 SNFs from data reported on the "Long Term Care Facility Integrated Disclosure and Medi-Cal Report" submitted to the Office of Statewide Health Planning and Development. The reports used were those with an end date during calendar year 1985. For facilities reporting for a period ending before December 31, 1985, the reported expenditures were inflated to make them comparable to reports ending December 31, 1985. An average Medi-Cal rate for calendar year 1985 was created by

weighting the Medi-Cal rates in effect for different time periods during the year by the number of days each rate was in effect.

- Analysis of the actual costs of 61 hospital based distinct part units for fiscal years ending July 1, 1985 to June 30, 1986. Figures for total costs, property costs and labor costs were taken from work sheets prepared by the Rate Development Section from the hospitals' Medicare Cost Reports. Labor hours and wage rates were derived from the Labor Report segment of the Hospital Disclosure Report submitted to the Office of Statewide Planning & Development.

- Analysis of patient-specific treatment need and service information on over 7,000 patients residing in facilities in California in June and July of 1987. Lewin and Associates, with the assistance of representatives of the facility associations, developed a patient assessment form which facilities completed on a predetermined percentage of their patients in residence during the sample time period. About 10 percent of the forms were verified by Medi-Cal field nurses on their routine visits to facilities.

- Interviews with 29 hospital discharge planners to assess problems they experience in placing patients in nursing homes.

- Analysis of trends in the supply, use, and payment for nursing home beds and services utilizing primarily data from the Office of Statewide Health Planning and Development, the state Department of Health Services, and the federal Health Care Financing Administration.

- Review of the literature and activities in other states relating to nursing home reimbursement systems.

- Review of working papers on 100 facilities to determine the numbers and types of reclassification made by the Review Section of the Office of Statewide Health Planning and Development in their desk reviews of the Long-Term Care Facility Disclosure Reports.

- Review of 100 facility audit working papers to ascertain the number and types of adjustments determined by the Audits and Investigations Division of the Department of Health Services in their annual routine field audits of a 15 percent sample of freestanding facilities.

Organization of the Report

This report is organized into the following chapters:

- Chapter II: Criteria for Evaluation of Reimbursement System. This chapter presents eight key policy goals for nursing homes that were articulated by interviewees. These are then translated into criteria against which the current reimbursement system and alternatives can be evaluated.

- Chapter III: Evaluation of the Current Reimbursement System. In this chapter the current flat rate system is assessed against the criteria articulated in Chapter II.

- Chapter IV: Other Options Considered. This chapter contains a discussion of two alternatives, which were considered (as directed

by the RFP) and which are not being recommended -- a full case-mix system and outcome-based reimbursement.

- Chapter V: Recommendations. Our suggestions for change in the reimbursement system are described and explained in this chapter.

- Chapter VI: Overall Level of California's Nursing Home Rates. The final chapter contains information and comments concerning California's overall level of Medi-Cal expenditures on nursing home care.

CHAPTER II: CRITERIA FOR EVALUATION OF REIMBURSEMENT SYSTEMS

A. DEVELOPMENT OF CRITERIA

The RFP specified seven criteria to be used in evaluating the relative success of the current reimbursement system and in assessing potential alternatives and/or modifications. To look more closely at the question of criteria, Lewin and Associates interviewed numerous individuals and organizations representing major parties with an interest in the issue of Medi-Cal reimbursement of nursing home care. Exhibit 1 displays the original criteria from the RFP and the range of suggestions generated by these interviews.

Exhibit 1

SUGGESTED CRITERIA FOR EVALUATION OF CURRENT SYSTEM AND ALTERNATIVES

SOURCE	CRITERION
RFP	• Includes incentives for improved quality, access, and efficiency
RFP	• Is economically and politically feasible
RFP/CAHF	• Is consistent with public policy directives
RFP	• Recognizes patient mix and source of payment
RFP	• Is compatible with state's payment mechanisms
RFP/CAHA	• Provides for accountability of funds
RFP/ADV	• Ensures that rate increases are passed on to work force
Admin	• Is administratively simple
CAHA	• Ensures availability of sufficient number of beds to meet current and projected local needs
CAHA	• Ensures that all patients have access regardless of payment source

CAHA	• Covers reasonable costs for required basic services including allowances that reflect the appropriate cost for doing business
CAHA/ADV	• Includes a system to review and reward quality patient care based on specific indicators of quality
CAHF	• Recognizes future long-term care labor requirements, e.g., nursing shortage, turnover problems
CAHF	• Includes property reimbursement which encourages capital formation and recognizes equity investment
Admin/ADV	• Ensures a "reasonable level of care"
Admin	• Allows flexibility to deal with special circumstances and the diversity within the state
CAHF	• Is equitable, e.g., between the freestandings and hospital-based distinct part units
CAHF	• Provides for transitional system
Admin	• Ensures enough providers in the program to provide reasonable access
Admin	• Is not inherently inflationary
Admin/ADV	• Is fair -- balances needs of recipients, taxpayers, providers
Admin	• Does not entail an increase in total costs
Admin	• Has fair peer groupings
Admin	• Accurately reflects costs
Leg/ADV	• Ensures access for special populations including heavy care patients

ADV: Advocates
CAHF: California Association of Health Facilities
CAHA: California Association of Homes for the Aged
ADMIN: Administration representatives
LEG: Legislative representatives

Source: RFP; Lewin and Associates interviews.

While there is diversity in the orientation of groups with an interest in these issues and in the relative importance they place on selected criteria, we found reasonable consensus around general criteria. Most of the interviewees demonstrated a good appreciation of the political, economic, and practical realities surrounding the issues.

In order to develop a manageable number of criteria, we synthesized the views described above into eight areas. For each area we have articulated a statement of the state's public policy goal:

Exhibit 2

PUBLIC POLICY GOALS CONCERNING MEDI-CAL FUNDING OF NURSING HOME CARE

AREA	POLICY GOAL
A. Access	Medi-Cal patients who need nursing home care should be assured of reasonable access to such care.
B. Quality	Medi-Cal patients in nursing homes should be assured of adequate quality of care.
C. Cost Control	The costs to the Medi-Cal program should be controllable and reasonable.
D. Accountability of Funds	Facilities should be accountable to the state to provide adequate care to patients with Medi-Cal funds received from the state without undue levels of profit.
E. Levels of Care	The state should have a coordinated continuum of long-term care options that provide the appropriate level of care to the Medi-Cal beneficiary.
F. Equity Among Providers	Providers should receive comparable payments for comparable services with allowances for legitimate differences in the costs of doing business
G. Administrative Feasibility	The reimbursement system should be administered with accuracy, timeliness, and efficiency at a reasonable administrative cost.
H. Simplicity	Policy makers, providers, and consumers should be able to understand the basic design of the reimbursement system.

While reimbursement policy can be extremely important in achieving California's goals for Medi-Cal nursing home care, it is only one of a range of available policy instruments. There are three other key means for achieving certain of these goals:

- The state can regulate the supply of beds through certificate-of-need review (the state terminated such review as of January 1, 1987). While there is not a simple relationship between the overall supply of beds and the assurance of reasonable access to care for Medi-Cal patients, the available supply of beds is a factor in accessibility.

- The state establishes standards for the licensure and certification of nursing homes and implements procedures to enforce these standards. The state has focused most of its efforts on achieving its quality of care goals on this policy approach by upgrading standards and tightening enforcement.

- The state determines the appropriateness of the levels of reimbursable care through preadmission screening and utilization review procedures. The state instituted as of July 1, 1986, a preadmission screening program and routinely reviews the appropriateness of care of residents residing in nursing homes through the Medi-Cal Field Offices.

Additionally, there are factors outside the state's control that can significantly affect the degree of achievement of a particular goal, for example:

- Changes in interest rates and in the federal tax laws can have an impact on the attractiveness of the nursing home business as an investment opportunity and thus can influence the supply of beds.

- Changes in the overall economy and in social values affect patterns of demand for placement of the elderly outside the home. For example, the increase of women in the work force has likely

reduced the ability of many families to care for their elderly parents at home.

- Changes in the overall economy, in social values, in federal immigration laws, and in training opportunities impact on California's labor market and the ability of facilities to hire and retain nursing and other personnel.

Thus, there is not a one-to-one correspondence between the reimbursement system and the state's policy goals. While the reimbursement system can influence the achievement of the policy goals, it cannot by itself ensure that the policy goals will be achieved. In order to take this relative role of the reimbursement system into account, we have translated each of the policy goals into a statement of what the reimbursement system can be expected to accomplish in that area. These are the criteria that will be used in subsequent chapters to evaluate the current system and alternatives and/or modifications.

Exhibit 3

CRITERIA FOR EVALUATING MEDI-CAL REIMBURSEMENT SYSTEM IN EACH POLICY AREA

AREA	CRITERION
A. Access	The reimbursement system has incentives that address problems in access experienced by particular populations.
B. Quality	The reimbursement system has incentives for facilities to operate in ways that enhance quality of care.
C. Cost Control	The total Medi-Cal costs for nursing home care are controllable.
D. Accountability of Funds	The reimbursement system allows for the targeting of funds to meet the state's objectives.
E. Levels of Care	The reimbursement system creates incentives for patients to receive the appropriate level of care.
F. Equity Among Providers	The reimbursement system accommodates legitimate differences among facilities in the cost of doing business.
G. Administrative Feasibility	The reimbursement system does not require a large administrative cost to implement with accuracy and timeliness.
H. Simplicity	The reimbursement system is easy to understand.

B. BALANCING OF GOALS

Some of the policy goals clearly conflict with each other. Too strong an emphasis on cost control can undermine the goal of adequate quality of care for Medi-Cal recipients. The complexity required to ensure equity among providers and/or to equalize access to care for all types of patients can reduce administrative feasibility. A system incorporating incentives for additional beds can jeopardize cost control objectives.

No reimbursement system can accomplish all the goals to their optimum level. The task of designing a system is thus to weigh policy objectives and balance the incentives contained in the system. In the process, the unique characteristics of California must be carefully considered, along with the context within which the current system operates and in which any changes would be implemented. The analysis that follows in subsequent chapters attempts to strike the most appropriate balance of policy goals within the context of California's political and economic circumstances, taking into account the structure of its nursing home industry, and the state's historical approach to public policy issues.

C. BUDGET NEUTRALITY

The RFP for this study indicates that one important criterion for evaluating options should be "economical and political feasibility." In our proposal and in the course of the study we have separated the issues of how much the state chooses to expend overall on Medi-Cal payments to nursing homes and how it will distribute whatever level of funds it expends, to create incentives that maximize its goals. Any reimbursement system (no matter what the overall level of the rates) will effect a distribution of payments that results from the particular method used in calculating rates.

Thus we discuss alternatives and make recommendations on reimbursement methodology in Chapters IV and V within the context of a budget neutral constraint, i.e., that the total funds expended will not be greater in the initial year than would be the case with a continuation of the current system. In Chapter VI we discuss the overall levels of Medi-Cal expenditures on nursing home care.

CHAPTER III: EVALUATION OF CURRENT REIMBURSEMENT SYSTEM

This chapter evaluates the current system of rate setting against the criteria established in Chapter II and indicates the areas in which there are significant problems in meeting the criteria or where the emphasis on one goal may have pushed the system out of balance.

The current flat rate system with its strong focus on cost control and simplicity has placed too little emphasis on accountability, quality of care, and special access problems:

- The current system has been effective until recently in controlling the state's Medi-Cal expenditures on nursing home care.

- The lack of sufficient accountability in the current system reduces the state's confidence that its funds are being spent appropriately and not resulting in excess profits to some facilities.

- The current system has financial disincentives for quality of care since facilities can earn higher profits by lowering patient care-related expenditures.

- There is a subset of heavy care Medi-Cal patients for whom there are barriers to access and potential quality of care problems because the cost of their care is higher than the current flat rate.

A. ACCESS CRITERIA: The reimbursement system should have incentives that address problems in access experienced by particular populations.

Under the current flat rate system, facilities have a financial disincentive to accept Medi-Cal heavy care patients, creating serious impediments to their ability to obtain care. In general Medi-Cal patients have more difficulty in obtaining access to nursing home facilities of their choice than other patients. This problem could become more serious in the future if the bed supply does not expand sufficiently to match the projected growth in the elderly population.

California's Supply of Beds Is Low Compared to National Figures and Has Not Been Growing as Rapidly as the Elderly Population

The supply of nursing home beds in California is lower than the national average. As indicated in Exhibit 4, in 1980 the state had 45 beds per 1,000 elderly (aged 65+) compared to a national average of 54. Even when the figure is adjusted to account for California's younger than average elderly population, the state is still below the national average.

Exhibit 4

ADJUSTED AND UNADJUSTED NUMBERS OF LICENSED NURSING HOME BEDS PER 1,000 ELDERLY AGE 65 AND OLDER IN 1980[1]

	Unadjusted	Adjusted[2]		Unadjusted	Adjusted[2]
Alabama	47	55	Montana	90	95
Alaska	45	55	Nebraska	91	89
Arkansas	64	73	Nevada	33	44
California	45	50	New Hampshire	61	65
Colorado			New Jersey	30	33
Connecticut	71	77	New Mexico	30	36
Delaware	64	73	New York	44	49
District of Columbia	26	30	North Carolina	31	37
Florida	22	26	North Dakota	78	83
Georgia	64	77	Ohio	61	68
Hawaii	43	51	Oklahoma	82	90
Idaho	48	56	Oregon	49	53
Illinois	69	76	Pennsylvania	51	58
Indiana	66	71	Rhode Island	69	74
Iowa	81	78	South Carolina	38	48
Kansas	89	90	South Dakota	82	82
Kentucky	47	90	Tennessee	51	59
Louisiana	60	71	Texas	76	87
Maine	69	72	Utah	51	58
Maryland	53	62	Vermont		
Massachusetts	64	66	Virginia	35	41
Michigan	47	52	Washington	62	68
Minnesota	87	86	West Virginia	23	26
Mississippi	52	59	Wisconsin	94	99
Missouri	62	66	Wyoming	64	74

[1] U.S. adjusted and unadjusted = 54. Massachusetts and Pennsylvania include licensed intermediate care beds for the mentally retarded; Ohio includes rest home beds.

[2] The number of nursing home beds was adjusted to reflect different proportions of elderly in different age groups, i.e., 65-74, 75-84, and 85 plus.

Source: GAO Report on Medicaid and Nursing Home Care, October 21, 1983.

This fact by itself is difficult to interpret because of potential variations among the characteristics of the elderly populations and in the range of alternative residential settings in each state. On both these factors there is some data suggesting that California's need for nursing home beds might be lower than average. California might be expected to have a lower need for nursing home beds if its elderly population were healthier than average. Evidence on this issue is not definitive, but one study found California's relative need for nursing home beds to be 37th among the 50 states when one considered the mortality rates of the noninstitutionalized elderly population in each state.* These mortality rates correlate with morbidity and are thus considered a reasonable indicator of the need for personal assistance which is a major predictor of nursing home bed need. California also has a large supply and variety of residential facilities for the elderly as well as a number of community services to support individuals in their homes as shown in Exhibit 5.

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* Unger, A. and Weissert, W. Data for Long-Term Planning: Application of Synthetic Estimation Techniques. Urban Institute, 1983.

Exhibit 5

ESTIMATED NUMBERS OF PERSONS SERVED
BY SELECTED LONG-TERM CARE PROGRAMS IN CALIFORNIA (1986)

Residential Care Facilities for the Elderly	76,000
Adult Residential	38,000
Adult Day Care	16,000
In-Home Supportive Services (IHSS)	119,000
Home Health Care	142,000
Home Delivered Meals	55,000
Transportation	69,000
Nursing Home Beds	118,000

Source: Legislative Analyst Budget Analysis, FY 86-87; Department of Social Services, Community Care Licensing Division, October 1986; OSHPD Annual Report of Hospitals and SNF/ICFs, 1986.

The growth in nursing home beds in California has not kept up with the growth in the elderly population, resulting in a declining ratio of beds to 100 elderly population. As indicated in Exhibit 6, the number of beds per 100 California residents aged 75 and above has dropped over the last decade from 13.1 to 9.7. It should be noted that this trend of a declining ratio of nursing home beds to number of elderly is characteristic of much of the country, although it is more pronounced in California. From 1978 to 1983, for example, there was a decrease in the ratio of nursing home beds to the

size of the aged population of 2.8 percent nationally, compared to a California 11.9 percent decline.*

Exhibit 6

GROWTH IN NURSING HOME BEDS IN CALIFORNIA
(1976-1986)

	1976	1978	1980	1982	1984	1986
Freestanding beds	105,389	105,203	106,345	107,561	109,370	112,697
Hospital-based distinct part beds	5,199	4,059	3,880	3,918	4,019	5,036
Total beds	110,588	109,262	110,225	111,479	113,389	117,733
Growth during prior two years		(-1,362)	963	1,254	1,910	4,344
Freestanding beds per 100 population aged 65+	5.1	4.7	4.4	4.2	4.0	3.9
Total beds per 100 population aged 65+	5.3	4.9	4.5	4.3	4.1	4.0
Freestanding beds per 100 population aged 75+	13.1	12.3	11.2	10.6	10.1	9.7
Total beds per 100 population aged 75+	13.8	12.8	11.6	11.0	10.5	10.2

Source: Office of Statewide Health Planning and Development Annual Census; State Department of Finance.

* Aging Health Policy Center, University of California, as reported in Improving the Quality of Care in Nursing Homes, Institute of Medicine, 1986.

Medi-Cal Patients Are Least Preferred by Nursing Homes

Facilities prefer most private pay and some Medicare sponsored patients because of the higher revenue they generate, so that these patients have considerably less difficulty than Medi-Cal patients in obtaining access to facilities of their choice. This fact has been noted by other studies and was confirmed in our interviews with nursing home operators and with hospital discharge planners. (More detail on the interviews with the discharge planners is provided in Chapter V and Appendix B.)

We asked discharge planners to rank the difficulty of placing different types of nursing home patients. We arbitrarily assigned a score of "1.0" to private pay light care patients and then asked each discharge planner whom we interviewed to assign a score to other patient types to reflect the relative difficulty of placing that type. For example, a score of "5.0" would mean a patient type was five times as difficult to place as a private pay light care patient.

As can be seen in Exhibit 7, both light and heavy care Medi-Cal patients were considered to be substantially more difficult to place than others. The most difficult of all to place were the heavy care Medi-Cal patients being discharged from hospitals that lacked a distinct part SNF. Even discharge planners at hospitals with distinct part units reported on average that heavy care Medi-Cal patients were over four times as difficult to place as private pay light care patients.

Exhibit 7

COMPARATIVE DIFFICULTY OF PLACING PATIENTS IN NURSING HOMES BY TYPE OF PATIENT AND TYPE OF HOSPITAL MAKING PLACEMENT: AVERAGE RELATIVE RANKINGS REPORTED BY DISCHARGE PLANNERS

		Discharge Planners at Hospitals with Distinct Part SNF	Discharge Planners at Hospitals Without a Distinct Part
Private pay:	light care	1.0	1.0
	heavy care	2.0	2.3
Dual eligibles/ crossovers*:	light care	2.5	2.9
	heavy care	3.0	4.0
Medi-Cal:	light care	3.5	4.1
	heavy care	4.8	16.4

* Patients who are dually eligible for Medicare and Medicaid.

Note: A score of "1" means the patient type is considered the least difficult to place; a score of "5" means the patient is considered five times as difficult as the easiest patient.

Source: Lewin and Associates survey of discharge planners, 1987.

Patients who were old enough to qualify for Medicare and already certified for Medicaid (the "crossover" population) were said to be somewhat less difficult to place than Medi-Cal only patients, though they were still rated as two and one-half to four times more difficult to place than light care private payers. The reason, we were told, that crossover patients were preferred to purely Medi-Cal patients is that such patients have a more generous and assured payer (Medicare) for ancillary services (e.g., physical therapy), drugs, and physician services. In addition, patients whose conditions qualify them for Medicare payment for the nursing home stay can in most cases generate higher revenues than Medi-Cal patients. Facilities, however, do risk having Medicare retroactively deny payment if the fiscal intermediary determines (after the care was rendered) that the patient's

condition did not warrant Medicare coverage, which makes Medicare patients less desirable than those who agree to and can pay privately for care.

The consequence of the lower preference for Medi-Cal patients is that some Medi-Cal patients are placed at substantial distances from their home and family. For example, one hospital discharge planner in Redding reported placing Medi-Cal patients in Yreka, which is about 200 miles away; a hospital discharge planner in the Stockton area reported placing most Medi-Cal patients in Modesto (40 miles away) and some as far away as Napa. The Medi-Cal Field Offices operate within a general guideline of considering placements acceptable if they are within a 60-mile radius, but no data is currently compiled on actual distances of placements. By comparison, most nursing home operators we talked to consider their market area for private pay patients to be a 5- to 10-mile radius around their facility.

Trends in Bed Use Also Suggest Fewer Choices for Medi-Cal Patients

These preferences are reflected in the changes in the composition of the nursing home population in the last few years. What growth there has been in freestanding nursing home beds has been filled by private pay patients while the number of Medi-Cal patients has actually declined as shown in Exhibit 8.

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* With regard to access for Medicare patients, several hospitals across the state reported that "many" nursing homes "request" a deposit from Medicare patients before they are admitted in case Medicare will not pay. The Health Care Financing Administration (HCFA) considers such preadmission requirements (even if phrased as a "request") to be in violation of Medicare regulations (42 C.F.R. Section 489.22(a)). The problem is not unique to California and HCFA has developed a procedure for dealing with the matter when it comes to their attention.

Exhibit 8

GROWTH IN MEDI-CAL AND OTHER PAYER ONE-DAY CENSUS
IN ALL FREESTANDING SNFs/ICFs*
(1980-1986)

	1980		1986	
	Number	%	Number	%
Medi-Cal	70,647	71.0	68,275	65.7
Medicare	2,362	2.4	2,856	2.8
Private Pay	25,112	25.2	30,210	29.1
Other	1,390	1.4	2,579	2.5
Total	99,511	100.0	103,920	100.1

* Data includes patients in ICF-DD and SNF-MD beds.

Source: OSHPD Annual Report of SNF/ICF Facilities.

The fact that the proportion of Medi-Cal patient days to total days has declined suggests that there has been a deterioration in access to care for Medi-Cal patients. Should the supply of beds continue to decline relative to the numbers of elderly in the state, this problem could become even more serious and affect even more Medi-Cal beneficiaries.

The Medi-Cal patient is more likely to find a bed in certain types of facilities. As shown in Exhibit 9, the average investor-owned facility has twice as many Medi-Cal patients as does the average not-for-profit nursing home.

Exhibit 9

MEDIAN PERCENT MEDI-CAL BY FACILITY OWNERSHIP
1985

Ownership	Median Percent Medi-Cal Days
Investor-owned	74.1
Chain	76.4
Non-chain	71.2
Not-for-profit	35.3
Non-church	50.0
Church	31.2
Government	83.6
Total	71.2

Source: Office of Statewide Health Planning and Development Annual Reports of SNFs/ICFs.

The Medi-Cal patient is more likely to be in a facility where there is a substantial number of other Medi-Cal patients. As indicated in Exhibit 10, about 32 percent of the Medi-Cal patients are in facilities that have more than 80 percent of their patients on Medi-Cal and another 33 percent are in facilities with between 60 and 79 percent Medi-Cal patients. Thus only the remaining roughly one-third of the Medi-Cal patients are in facilities that have a substantial number of nonMedi-Cal patients.

Exhibit 10

DISTRIBUTION OF FACILITIES BY PERCENT OF PATIENTS THAT ARE MEDI-CAL 1985

Percent of Medi-Cal Patients in the Facility	Facilities	
	Number	Percent
Less than 20% Medi-Cal	141	11.8
20-39% Medi-Cal	112	9.4
40-59% Medi-Cal	166	13.9
60-79% Medi-Cal	394	33.0
Over 80% Medi-Cal	381	31.9
	1,194	100.0

Source: Office of Statewide Health Planning and Development Annual Reports of SNFs/ICFs.

Perhaps most importantly, the Medi-Cal patient is more likely to be in a facility that spends less on direct patient care related activities. As shown in Exhibit 11, in our analysis of 1985 cost reports we found an inverse relationship between the amount spent per day on these items and the percentage of Medi-Cal patients in the facility. For example, facilities with more than 75 percent of their patient days being Medi-Cal spent $26.68 per patient day on these direct care items, compared to those with fewer than 25 percent of the patient days being Medi-Cal who spent $41.85 per patient day.

Exhibit 11

RELATIONSHIP OF PERCENT MEDI-CAL PATIENTS IN A FACILITY TO EXPENDITURES ON PATIENT-RELATED ITEMS (1985)

Percent of Medi-Cal Patients in Facility	Expenditures Per Patient Day						
	Nursing		Dietary		Social Svcs.		Total
	$	%	$	%	$	%	$
Under 25% (N=136)	31.71	46	8.90	13	1.24	2	41.85
25 - 50% (N=143)	23.49	45	6.96	13	1.17	2	31.62
50 - 75% (N=336)	20.76	45	6.12	13	0.84	2	27.22
Over 75% (N=399)	19.94	44	5.90	13	0.84	2	26.68

Source: Lewin and Associates cost analysis.

Trends in Nursing Home Supply and Demand Are Difficult to Predict

The question of the growth in future supply and demand is critical in assessing potential future access problems for Medi-Cal patients, but supply and demand are difficult to predict with any precision.

- Demand-related variables:

Estimating demand for nursing home care is difficult. One can estimate demand based on current patterns of use, but the multiplicity of factors that impact those use rates are all subject to change so that prediction is speculative. The elderly segment of California's population, particularly the over-75 and over-85 year old portion, is projected to grow rapidly over the next two decades. If the elderly continue to use nursing home care at the same rate as in 1986, an additional 30,000 beds would be

needed by 1995 to accommodate the growth in the elderly population. These projections are shown in Exhibit 12.

Exhibit 12

PROJECTIONS OF ONE-DAY CENSUS BED NEED ASSUMING 1986 USE RATES CONTINUE*

	Actual Census		Projected Census			
	1980	1986	1990	1995	2000	2020
Medi-Cal one-day census	70,647	68,275	77,526	87,861	97,791	132,441
Non-Medi-Cal one-day census	28,864	35,645	40,475	45,870	51,055	69,145
Total one-day census	99,511	103,920	118,001	133,731	148,845	201,586

* Use rate calculated in 1986 as census days in freestanding SNF/ICFs ÷ population in three age categories (under 65, 65-74, over 75) and then multiplied by population projections by age group for subsequent years.

Source: OSHPD Annual Report of SNF/ICF; State Department of Finance; Lewin and Associates calculations.

Other factors which will influence the demand for nursing home care are difficult to predict. Successive cohorts of the elderly are healthier overall but more individuals are living longer with chronic illnesses because of the advances in medical technology. The net impact of this changing demography on need for long-term care beds cannot be accurately anticipated.

Changes in social, cultural, and economic factors also impact upon the demand for nursing home care. The increase of middle-aged women in the work force, for example, reduces the ability of some families to care for an elderly parent who needs constant attention. As David Mechanic indicates in a recent article:

> Long-term care is a social process, more so than is the provision of traditional health care as we usually view it. It depends to a larger degree on notions of community, networks of reciprocal obligation, and competing and changing values among the generations.*

There is growing interest in the development of both public and private insurance mechanisms for financing long-term care which might stimulate the demand for nursing home care. Some insurance companies are selling long-term care policies. The elderly and their families are becoming wealthier and more able to afford care, both in institutions and at home. The net effect of all these changes on the demand for care is indeterminate. There may be a reduction in demand, but just as likely there could be an increase. A sizeable increase in demand that would be reflected in higher than 1986 use rates could create pressure for bed additions beyond what is shown in Exhibit 12 above.

- Supply-related variables:

Against this uncertainty in future demand is an equally complex picture on the supply side. Bed growth has increased more rapidly in the last two years, and the rising occupancy rate in freestanding facilities has leveled off, as shown in Exhibit 13. Over these last two years the bed supply has grown by about 2,000 beds per year, about one-quarter of which have been added in hospital-based distinct part units.

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* "Challenges in Long-Term Care Policy," D. Mechanic, Health Affairs, Summer 1987.

Exhibit 13

OCCUPANCY IN CALIFORNIA FREESTANDING NURSING HOMES

Year	Occupancy Rate
1976	89.6%
1977	91.0
1978	92.8
1979	93.5
1980	93.5
1981	93.5
1982	93.8
1983	94.0
1984	94.3
1985	93.6
1986	93.0

Source: OSHPD Annual Report of SNF/ICFs.

The state removed certificate-of-need review for the addition of long-term care beds effective January 1, 1987. When the program terminated, there were approximately 22,000 beds which had received CON approval, but were not yet built. After January 1, 1987, prospective builders must notify the state of intentions to add beds, even though the state has no review and approval authority. As of September 23, 1987, the state had received notices of intention to build and/or expand from 118 interested parties who propose adding 6,600 more beds. If all of these beds (those with CON approvals from before January 1, 1986, and those who have noticed intentions since then) were built, the supply of beds would increase by nearly 25 percent.

An unanswered question is how many of these beds will actually be constructed. We interviewed a sample of 12 representatives of prospective facilities who were on record with plans either to add beds to an existing nursing home or to build an entire new structure. Some have approved CONs from before 1987 and some have noticed their intent since January 1987. All 12 indicated that they still expect to proceed with the additions although a

few have scaled back their plans in response to other proposed building in their area.

The most dramatic growth in supply has been the establishment of hospital-based distinct part units. The pressures on hospitals that underlie this trend are likely to continue. Hospitals are eager to fill unoccupied beds with alternative services, such as long-term care, that appear profitable, particularly when facing the prospect of empty beds. Having a unit under the hospital's control is also perceived as a benefit in adapting to Medicare's prospective payment DRG system, which encourages earlier discharges from acute care settings.

The impact of the recent changes in the federal tax laws is difficult to predict. Certain provisions, e.g., changes in the investment tax credit, depreciation schedules, and rules regarding the treatment of passive investor losses, would appear to be detrimental to those considering new construction. The drop in the tax rate is a beneficial aspect of the reform package for prospective investors.

Medi-Cal Patients With Heavy Care Needs Have Special Access Problems

The current system has a disincentive for nursing homes to accept heavy care Medi-Cal patients, so that this particular segment of the Medi-Cal population has special problems in being placed in a nursing home. (The characteristics of this patient population will be discussed in greater detail in Chapter V.) The flat rate system creates a clear disincentive to accept patients whose cost of care will substantially exceed the reimbursement rate.

This problem of placing heavy care Medi-Cal patients has been noted in the state for a number of years. A pilot project in San Diego County in the early 1980s was designed in part to obtain access for some of these

patients (those requiring special nursing care) by paying facilities an increment over the usual Medi-Cal rate for their care. The subacute category recently created for Medi-Cal patients was initially designed to accommodate this type of patient. The Department of Health Services, in developing regulations, narrowly defined the group of patients who qualify for subacute rates. The Department estimates that only 300 to 500 patients will require the exceedingly high treatment needs necessary to be considered a subacute patient.

Our interviews with hospital discharge planners as indicated above showed that the Medi-Cal heavy care patient is by far the hardest patient to place. Some patients, according to Medi-Cal field office staff, are essentially unplaceable, remaining in hospitals in some cases for years. One discharge planner described an 89-year-old Medi-Cal patient who had been awaiting placement for one year. She was a bilateral amputee who was diabetic and required total care. Another discussed a Medi-Cal patient who was placed after 1½ years in the hospital. The patient had several large decubiti, was incontinent, needed to be fed, was confused, and did not ambulate. Another example was a patient who has been in the hospital for over a year. He is a young patient with a spinal cord injury, has a decubitus, and needs total care.

The state pays for acute administrative days for these patients while they remain in the hospital awaiting placement. The rate is equal to the median for hospital based distinct part units, currently around $152/day. As shown in Exhibit 14, these acute administrative days increased substantially during the last fiscal year, costing the state approximately $10 million.

Exhibit 14

ADMINISTRATIVE DAY TREATMENT AUTHORIZATION REQUESTS GRANTED

Medi-Cal Field Office	Days Granted 1984-85	1985-86	1986-87	Percent Increase 84-85 to 86-87
Los Angeles	8,538	12,967	27,988	228
Modesto	8,682	9,944	14,397	66
Redding	3,218	3,671	4,976	255
Sacramento	1,623	4,942	10,689	559
Santa Barbara	1,557	2,890	2,482	259
San Bernardino	10,678	9,934	12,398	16
San Diego	37,743	21,721	34,480	(-9)
San Francisco	3,253	3,643	3,892	20
Oakland	748	771	3,120	317
San Jose	2,421	3,784	6,812	181
Santa Rosa	892	591	714	(-20)
Fresno	987	1,564	2,955	199
Total	80,340	76,422	124,903	55
Total expenditures ($ millions GF)	$5.7	$6.1	$10.5*	

* 1986-87 annualized from 6 months data.

Source: Medi-Cal Field Office Division; Medi-Cal Services and Expenditures Month of Payment Reports.

While good data on the nature of Medi-Cal administrative days is not available, it appears as if some of these are for heavy care patients for whom placement cannot be arranged. (The other major cause is likely to be Medi-Cal pending patients whom facilities will not accept until their Medi-Cal eligibility has been firmly established.)

The impediments to access experienced by the heavy care Medi-Cal patient appear to us to be independent of bed supply and the general access problems of Medi-Cal patients. Most facilities perceive the care of these patients to be too costly to provide under almost any circumstances. It is only with persistence that a placement is ultimately obtained.

Conclusions

- The flat rate system creates disincentives for facilities accepting heavy care Medi-Cal patients. The existence of a clear and serious problem for these patients in being assured of reasonable access to care was substantiated through interviews with hospital discharge planners.

- The general Medi-Cal patient with light or moderate care needs has less choice in facilities and is sometimes placed far from home and relatives. Medi-Cal patients are also more likely to be placed in facilities with lower expenditures on patient care related items and in facilities that have a large proportion of Medi-Cal patients. There are indications that access to care has been deteriorating. A continuing decrease in the number of beds per elderly in the state would create a significant problem in access for a much larger share of Medi-Cal patients. There is, however, substantial uncertainty about future demand and supply, with some indications that supply might continue the more rapid growth rate of the last two years.

B. QUALITY OF CARE CRITERIA: The reimbursement system should have incentives for facilities to operate in ways that enhance quality of care.

There has been considerable concern on the part of the Legislature and the public about the quality of care in California's nursing homes. For example, a Little Hoover Commission report in 1983 led to reform legislation in 1985 (SB 53/AB 180) which increased the magnitude of regulatory activity. A follow-up report by the same commission in 1987 commended the state on some improvements in enforcement activity, but recommended additional quality of care issues the state should address.

Quality of care is difficult to define and measure, and a direct relationship between expenditures and quality cannot be assumed. However, higher expenditures on direct patient care expenses are generally considered, with some empirical support, to be a proxy or indicator of a higher standard of quality of care. For example, the Department of Health Services conducted a major study of the relationship of surrogate measures of quality of care with various facility characteristics based on 1980 data. In general, the study found small but statistically significant relationships between:

- More nursing hours and fewer inspection deficiencies and citations;
- Lower staff turnover and fewer inspection deficiencies and citations; and
- Higher total expenditures and fewer inspection deficiencies and citations.

We also looked in our cost analysis at the relationship between expenditures and staff turnover, using 1985 data, and confirmed that higher nursing wages were associated with lower staff turnover.

Our charge for this study was not to assess the quality of care in California nursing homes, but rather to assess the relationship between the state's current Medi-Cal reimbursement system and the goal of promoting quality of care. It can be said with considerable assurance that the current Medi-Cal reimbursement system per se contains no incentives to promote quality of care; rather, the system positively rewards reductions in expenditures whether those reductions occur through increased efficiency in administration or reduced nursing hours.

Under the current system, any additional dollars that a facility spends on patient care reduce the facility's profits or increase losses on Medi-Cal patients. It was not surprising, therefore, to find in our cost analysis on 1985 SNF data that:

- The greater the proportion of Medi-Cal residents in a facility, the lower the spending on nursing care (Exhibit 11). This variation might be appropriate if Medi-Cal residents required less care than private payers. In our Resident Assessment Study, however, we found that the case mix of private payers was about the same as that of Medi-Cal patients. (More details on the Resident Assessment Study are found in Chapters IV and V.)

- Facilities that made the most profit on Medi-Cal patients spent the least on nursing and other direct care items as shown in Exhibit 15.

Exhibit 15

RELATIONSHIP OF PROFITABILITY* ON MEDI-CAL PATIENTS TO EXPENDITURES ON PATIENT-RELATED ITEMS (1985)

	Expenditures Per Patient Day						
	Nursing		Dietary		Social Svcs.		Total
	$	%	$	%	$	%	$
Medi-Cal rate more than 10% higher than average total cost (N=)	18.41	47.4	5.48	14.1	0.63	1.6	24.52
Medi-Cal rate between 0 and 10% higher than average total cost (N=304)	19.18	45.0	5.70	13.3	0.80	1.9	25.68
Average total cost between 0 and 10% higher than Medi-Cal rate (N=342)	20.57	44.3	6.09	13.1	0.83	1.8	27.49
Average total cost between 10 and 25% higher than Medi-Cal rate (N=155)	23.36	44.8	6.74	12.9	0.91	1.8	31.01
Average total cost between 25 and 50% higher than Medi-Cal rate (N=80)	26.48	43.3	8.30	13.5	1.36	2.2	36.14
Average total cost more than 50% higher than Medi-Cal rate (N=68)	41.50	47.2	10.86	12.8	1.98	2.3	54.34

* Expenditures in this table have not been reduced for Medi-Cal nonallowable costs generally ranging around 4-5% in field audits. Profits may thus be understated by about 4-5%.

Source: Lewin and Associates cost analysis.

The Legislature has been reluctant to simply augment rates under the flat rate methodology since there is no assurance that these dollars would be spent on patient-related items related to quality of care. The Legislature has attempted through the "labor passthrough" to tie augmentations and cost-of-living increases to the requirement that facilities spend the funds on increased wages and/or total labor expenses. While this provides some accountability for these augmentations, it is a relatively inefficient process and does not address the basic differences among facilities in the amounts spent on patient-related items.

The checkered history of the labor passthrough indicates both the state's commitment to trying to ensure that more money go to resident care and the complexities of using the labor passthrough for that purpose:

- Chapter 19 (Statutes of 1978) augmented rates by $2.28 per patient day and required that this entire amount be spent on nonadministrative employees by raising entry wages and making one incremental increase in hourly wage after three months of employment.

- Chapters 10 and 11 (SB 53/AB 180; Statutes of 1985) provided funding for a labor passthrough to nonadministrative employees -- $3.14 (SNF)/$2.76 (ICF) to go for increases in wage rates for all nonadministrative employees and $1.18 per patient day to be used to increase overall nonadministrative salary expenditures.

- FY 1985-86 and 1986-87 Budget Control language required facilities below the median to pass through 75 percent of the cost-of-living increase on the portion of the rate estimated to represent labor costs (approximately 65 percent) to nonadministrative employees.

- Similar FY 1987-88 Budget Control language was vetoed by the governor.

- AB 1272 passed by the Legislature but not signed by the Governor would have augmented rates by $1.25 for SNFs, all of which was to be used by each facility to increase its total expenditures on nonadministrative personnel.

The labor passthrough, while clearly better than nothing, is not an efficient way of ensuring expenditures on direct care items.

- The labor passthrough formulas are difficult for facility management to understand, for auditors to monitor, and for employees to calculate.

- The labor passthrough only addresses the use of augmentations to the basic rate and does not deal with the fundamental disparity among facilities in the base amounts spent on patient care-related items.

- The labor passthrough augmentations provide additional Medi-Cal funds to some facilities who are already spending a high amount on patient care-related items which may not be the best use of Medi-Cal funds.

- The results of the initial audits of the SB 53/AB 180 passthrough indicate an error rate of around 12 percent. Given the large amount of auditor time needed to conduct these reviews, the number of facilities that can be audited will be only around 5 percent in the current fiscal year. Even though the error rate diminishes somewhat as the requirements become better understood, the state and/or employees will lose the possibility of recoupment of

substantial sums because so few of the facilities will be audited. (More information on these audits is found later in this chapter in the section on Administrative Feasibility.)

- The labor passthrough is not a statutorily mandatory part of the rate-setting methodology and is thus influenced by political considerations each year.

Conclusions

- There is no incentive under the current flat rate reimbursement system for facilities to spend on direct patient care-related items that contribute to higher quality of care.

  -- Facilities that spend low amounts can retain the savings as profit.

  -- The labor passthrough, while better than nothing, is an inefficient and not statutorily required means of dealing with the basic disparity of expenditures among facilities on patient care-related items.

C. COST CONTROL CRITERIA: **The total Medi-Cal costs for nursing home care are controllable.**

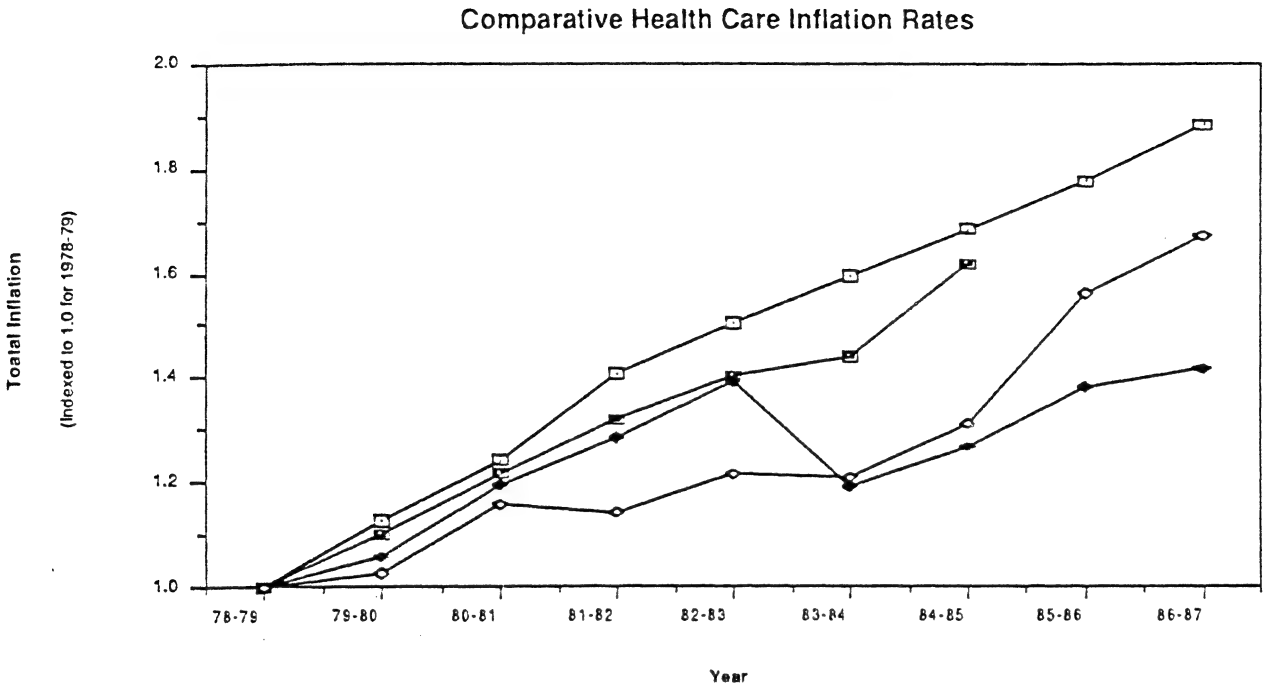
The current flat rate system has contributed to relatively controlled growth in Medi-Cal expenditures on nursing home care, particularly until the last two years.

Growth in Medi-Cal
Expenditures on Nursing Home Care

California Medi-Cal expenditures on long-term care as well as Medi-Cal expenditures in general have grown less rapidly than overall health care prices, as can be seen in Exhibit 16, which displays rates of growth in expenditures compared to a base of Fiscal Year 1978-79. The rate of growth of Medi-Cal expenditures on nursing home care was lower than for the overall Medi-Cal program from 1978 to 1983, but this trend has reverswed since then, in part because the hospital segment of the Medi-Cal budget has been constrained because of selective contracting.

Exhibit 16

RATE OF GROWTH OF MEDI-CAL NURSING HOME EXPENDITURES



Source: State of California, Office of the Legislative Analyst; Medi-Cal services and expenditures month-of-payment reports (figures include ICF-MD and ICF-DD); OSHPD Aggregate Long Term Care Financial Data.

California's Medi-Cal expenditures for long-term care (excluding ICF-DD) grew less rapidly than the national average during the late 1970s and early 1980s. The last three federal fiscal years have shown a different pattern, however, with substantially higher rates of increase in California than nationally.

Exhibit 17

PERCENTAGE GROWTH IN MEDICAID EXPENDITURES ON NURSING HOME CARE*

Federal Fiscal Years	Percent Increase	
	California	National
FY 79 to FY 83	13.5	40.1
FY 83 to FY 84	12.4	6.3
FY 84 to FY 85	12.9	9.1
FY 85 to FY 86	16.2	7.2
FY 79 to FY 86	74.0	67.0

* Data do not include ICF-MR.

Source: Health Care Financing Administration (HCFA) Annual Medicare and Medicaid Statistics, 1979-1984; HCFA Office of Medicaid Estimates and Statistics.

Flat rate systems, such as California's, have been shown to be an effective means of controlling costs since they maximize the facilities' incentive to restrain their expenditures. In the late 1970s and early 1980s the state allowed only moderate increases in inflation updates and minimal augmentations so that the flat rate system effectively controlled expenditure growth. Inflation adjustments in the last few years and the augmentations in SB 53/AB 180 in 1985 have resulted in higher Medi-Cal rates paid to facilities. The extent to which these funds will actually be expended by facilities on allowable costs and thus become part of the subsequent cost base to determine future rates remains an open question. The labor passthrough requirements of SB 53/AB 180 and of part of the budget COLAs in FY 1985-86 and FY 1986-87 would, if abided by, maintain the higher levels of expenditures.

Growth in expenditures is a result of both the rates and the number of beneficiary days. The latter has not grown from FY 1978-79 to FY 1985-86, as shown in Exhibit 18, so that all of the increase in Medi-Cal expenditures on nursing home care is a consequence of the increase in rates. This lack of growth in the beneficiary population has been an obvious factor in the control of Medi-Cal expenditures on nursing homes. Medi-Cal beneficiaries often have a share of cost that they pay to the facility so that the Medi-Cal expenditures on nursing homes do not reflect the full picture. Unfortunately, no source of data is available within California to determine trends over time in beneficiary share of cost expenditures on nursing home care.

Exhibit 18

COMPONENTS OF INCREASE IN MEDI-CAL EXPENDITURES ON NURSING HOME CARE

	FY 1978-79	FY 1985-86	% Increase
Medi-Cal patient days	25,849,630	25,813,829	(-0.1)
Average Medi-Cal payment per day	$23,17	$38.55	66.4
Total expenditures ($000s)	$598,919	$995,243	66.2

Source: Medi-Cal services and expenditures month-of-payment report.

Conclusions

The current system creates strong incentives for facilities to constrain expenditures. As a consequence of these incentives, of the moderate increases in inflation adjustments, and of the lack of growth in the number of

Medi-Cal nursing home patient days, there were only modest and controlled increases in Medi-Cal expenditures on nursing homes in the late 1970s and early 1980s. Legislative augmentations and more generous cost-of-living increases in the last few years have resulted in a more rapid growth in expenditures.

D. ACCOUNTABILITY OF FUNDS CRITERIA: The reimbursement system should allow for the targeting of funds to meet the state's objectives.

Under the current flat rate system, the state is constrained in its ability to target funds to ensure that facilities spend them as the state desires or expects. Further, because a particular facility's actual costs have no direct relationship to its rate there is little incentive for either the facilities or the state to have an accurate, timely, and comprehensive reporting, accounting, and auditing system. So not only does the state have difficulty directing facility expenditures, it also cannot be sure after the fact how funds have actually been spent. A final problem in the area of accountability is the lack of consistency in the use of inflation adjustments which reduce the public predictability of the rate process.

Under the Flat Rate System
It Is Difficult to Target Funding

While the rates are constructed by analyzing expenditures on particular components (e.g., labor, fixed costs), a facility can spend its Medi-Cal dollars any way it desires. And, as is noted in other parts of the report, there are substantial variations among facilities in their expenditures on items of concern to the state, e.g., expenditures on direct patient care related items.

Since the current reimbursement system maximizes the incentives for efficiency, there has been a long-standing concern in California that certain segments of the industry have earned excess profits at the expense of quality of care. Under the flat rate system, there are no distinctions between dollars of profit earned by efficiency in operations and dollars saved by skimping on quality of care. As noted earlier, facilities with high profits on Medi-Cal patients have lower patient-related expenses.

The Legislature has attempted to obtain some accountability by targeting rate augmentations specifically to selected salaries and wages (the "labor passthrough"), but these efforts have not dealt with the base of the rate and are not a routine part of the rate-setting methodology. (See section on Quality for more details.)

Accounting and Reporting Requirements Are Not Uniformly Met

Under the current system, each long-term care facility must complete and send to the Office of Statewide Health Planning and Development (OSHPD) a Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report within four months of the close of its fiscal year. The Office's responsibility is limited to ensuring the consistency and accuracy of the Disclosure Report and does not include any involvement in the review of the Medi-Cal component of the report or in the determination of Medi-Cal nonallowable costs.

The Office conducts a desk review of the submissions to verify the accuracy of the facility's classification of items. A summary report by OSHPD on this desk review process for fiscal year 1985-86 indicates that nearly one in six financial data items required corrections and these corrections averaged more than $100,000. The report states, "While some of these errors offset each other and reduce their effect on statewide totals and averages, these errors can have substantial impact on the accuracy of individual reports."

We reviewed OSHPD working papers on 100 facilities' cost reports to ascertain the numbers and types of reclassifications made by the OSHPD Review Section in their desk reviews. A summary of the areas in which most of the errors occurred is shown in Exhibit 19.

Exhibit 19

AREAS OF ADJUSTMENT MADE BY OSHPD IN DESK REVIEWS
OF LONG-TERM CARE DISCLOSURE REPORTS
(1985-86)

Area of Adjustment	Volume	Percent
Administration	96	15.5
Fixed Assets	93	15.0
Skilled Nursing Care	70	11.3
Education	57	9.2
Other Ancillary	48	7.7
Intermediate Care	45	7.2
Patient Supplies	28	4.5
Housekeeping	25	4.0
Dietary	25	4.0
Social Services	24	3.9
Laundry	23	3.7
Bad Debt	18	2.9
Plant Operations	17	2.7
Mentally Disordered	12	1.9
Developmentally Disabled	10	1.6
Other	30	4.9
	621	100.0

Source: Lewin and Associates review of OSHPD working papers.

The cost reports used by the Rate Development Branch to determine rates have not been subjected to these OSHPD desk reviews. The Branch abstracts information from the cost reports as they are submitted by the facilities. Because the rate-setting process only requires determining the medians within broad cost categories, the accuracy of individual reports has not been a priority concern.

A small sample of facilities also receives on-site audits to determine how well they are complying with the accounting portion of OSHPD regulations. The field audit is conducted by the Department of Health Services Audits and Investigations Unit as part of their annual rate audits to determine Medi-Cal nonallowable costs. Regulations require that the accounting records kept by the facility correspond exactly to the Accounting and Reporting Manual Chart of Accounts rather than being reclassified into appropriate categories when the report is prepared at year end. A summary report by OSHPD on findings from these field audits on FY 84-85 cost reports indicated only minor variations between the facilities' accounting systems (Chart of Accounts) and the required systems. Conversations with OSHPD representatives, however, indicate that more recent audit findings have disclosed a more serious compliance problem with the Chart of Accounts. The following represents our summary of the types of errors that have been found during these field audits.

Exhibit 20

TYPES OF ERRORS IN ACCOUNTING FOUND IN ON-SITE REVIEWS BY DEPARTMENT OF HEALTH SERVICES AUDITS AND INVESTIGATIONS UNIT

	Audits Performed During FYE (10 facilities) 6/30/87	(9 facilities) 6/30/86	(33 facilities) 6/30/85
Chart of Accounts Examination			
Account numbers not consistent with manual	6	2	15
Natural classifications not consistent with manual	3	2	3
No cross-reference for non-compliant accounts	5	2	11
No modification request	5	5	12
Other Areas			
Patient day discrepancies	5	2	14
Labor turnover discrepancies	5	5	16
Incorrect treatment of depreciation	4	3	10
Incorrect reporting of gross revenue	4	2	2
Incorrect use of statistics for allocating laundry/linen and patient meals	8	9	24

Source: Lewin and Associates review of Department of Health Services Audits and Investigations Unit working papers.

Because of the small sampling and the lack of detail in the audit program we are not able to independently determine the magnitude or seriousness of the noncompliance with the Accounting portion of the OSHPD regulations.

Audits of Medi-Cal Nonallowable Costs Consistently Reveal Problems

Each year the Department of Health Services Audits and Investigations Unit field audits a randomly selected sample of about 15 percent of the facilities. The purpose of the audits is to determine whether there are reported costs that are unrelated to patient care or are unreasonable based upon the Medicare regulations defining allowable costs. Any nonallowable costs are removed from the historical cost base used in calculating the Medi-Cal rates.

The Rate Development Branch calculates a simple ratio of audited allowable costs to reported costs for each SNF and ICF size category based on the sample audits. This ratio is then applied to all the facilities within the class. The effect is to reduce the median facility cost within each category by the applicable audit adjustment.

The Auditor General in a 1985 report indicated that the field audits have consistently found that from 3 to 5 percent of total reported costs were, in fact, nonallowable. We reviewed 100 facility audit working papers from the Audits and Investigations division to determine the types of audit adjustments that were made (Exhibit 21).

Exhibit 21

SUMMARY OF TYPES OF AUDIT ADJUSTMENTS

Type of Proposed Adjustment	Volume	Percent
Return on equity	483	35.2
Nonpatient related costs (nonallowable costs)	260	19.0
Other cost centers - Other	116	8.5
Administration - Other	95	6.9
Revenue abatement	84	6.1
Depreciation, leases	75	5.5
Routine services - Salary	70	5.1
Administration - Salaries	49	3.6
Home office	47	3.4
Property tax	42	3.1
Ancillary - Other	27	2.0
Revenue adjustments	12	.8
Ancillary - Salary	6	.4
Other - Salary	6	.4
	1,372	100.0

Examples of Non-Allowable Costs

Cable Television
Assessment of Income Tax Penalty
City Income Taxes Based on Gross Receipts
Voluntary Contributions
All Costs Nonreimb Apt Bldg
Personal Items
Interest Penalties
Rental of Decorative Paintings
Appraisal Fee in Connection with Loan Application
Travel Expense
Parking Ticket
Capitalized Leasehold Rights
Intercompany Profits
Car Phones
Ambulance Expense
Public Relations Specialist
Interest Expense on Loan from Stockholder
Bank Overdraft
Revaluation of Sale
Income Tax Preparation (Corporation)
Legal Fees
Lack of Supporting Documentation

Source: Lewin and Associates review of 100 facility audit working papers of the Department of Health Services Audits and Investigations Unit.

The types and amounts of adjustments have not changed substantially over the years. Under the current system, a facility which does not correctly report its costs is not subject to any sanctions, and its individual rate is not affected by any audit adjustments made to its individual cost report. Because facilities have no direct interest in the audit of their cost reports they usually waive their right to exit conferences with the auditors and only infrequently file appeals of the auditors' findings.

The California Association of Health Facilities (CAHF) believes there are substantial errors in the auditing process that result in a higher level of disallowances than is appropriate. Because the auditors' adjustments are not generally challenged by the facilities (either in exit interviews or appeals), CAHF believes that the audit process has not been held to a high standard of performance and that a sizeable number of the audit exceptions are in fact errors on the part of the auditors.

Flexibility in the Inflation Factor

There is considerable flexibility under the current state plan as to the selection of the inflation update applied to the labor component of the rate. To update costs from the base year through the December before the rate year, the state uses data from the Employment Development Department. These data are derived from employment information submitted by nursing homes for use in determining unemployment insurance payments. Another factor is then applied to update the cost component from January to July of the rate year and yet another factor (until recently the cost of living increase in the budget for state employees) is used for the period from July to the midpoint (December) of the rate year. For FY 1987, the Rate Development Branch used Data Resources Incorporated (DRI) projections based on national nursing home data for the latter two portions of this update.

The application of this inflation update is the most significant variable in the annual rate-setting process, and the lack of an agreed-upon index that is used consistently each year, in our view, opens the rate-setting process to behind the scenes negotiation. In a more predictable and stable system, facilities would know what to expect in terms of an inflation adjustment.

Conclusions

There are three essential problems with the current reimbursement system in terms of accountability.

- Because the state cannot easily target funds under the basic flat rate structure it cannot be assured that its dollars are being expended to promote its policy objectives, namely higher quality of care through appropriate expenditures on direct patient care items.

- Because facility rates are not directly affected by their individual cost reports, there has not been sufficient attention to the accounting, reporting, and auditing functions that are necessary to ensure an accurate accounting of the expenditures of Medi-Cal dollars.

- The lack of consistency in the use of an inflation factor for the labor portion of the rate reduces the certainty and public credibility of the rate-setting process.

E. LEVELS OF CARE CRITERIA: The reimbursement system creates incentives for patients to receive the appropriate level of care.

California Has Very Few ICF Beds

California has a much lower proportion of ICF beds (3.9 percent of beds and 4.4 percent of patient days in 1986) than most other states for a complex set of reasons only some of which are related to the reimbursement system. ICF rates were initially set at 80 percent of SNF rates and have fluctuated around this ratio in recent years. Some providers contend that they cannot operate ICF beds profitably since the staffing and facility requirements for ICFs are closer to the SNF standards than the 20 percent differential in rates.

Under the current system, a facility will continue to be paid at the SNF rate for a patient who needs only an ICF level of care if no ICF bed is available in the community. Because there is a shortage of ICF beds in many communities there is not always an alternative placement available. In addition, Medi-Cal Field Service staff are reluctant to move a patient to an ICF bed in another facility because of the trauma that a change in setting can create. This combination of factors leads to a perpetuation of the current low ratio of ICF to SNF beds.

The important question is whether the shortage of ICF beds indicates that patients are being inappropriately placed either in too high a level of care, SNFs, or too low a level of care, residential care facilities. Our assessment of acuity levels in a sample of patients in California indicated a smaller proportion of patients with lower care needs than, for example, in the state of Minnesota, from which we have comparable data (Exhibit 22). For example, in Minnesota 25 percent of the nursing home residents have 0-3 limitations in basic activities of daily living (ADLs), a relatively lighter level of care need, whereas in California only 7 percent of the residents in freestanding SNFs fit this category. This finding suggests that patients with lower level of care needs that might be occupying ICF beds in other states in SNF beds in California.

Exhibit 22

COMPARISON OF THE DISTRIBUTION OF NURSING HOME RESIDENTS IN CALIFORNIA AND MINNESOTA BY CASE MIX CLASS

Case-Mix Class	California		Minnesota
	Hospital-Based	Freestanding	
I. Low ADL* (0-3) Dependencies			
A. (No special problems or needs)	5.6%	6.6%	25%
B. (Behavior problems)	3.6	7.6	10
C. (Special nursing)	1.5	0.6	1
II. Medium ADL (4-6) Dependencies			
D. (No special problems or needs)	13.0	12.6	9
E. (Behavior problems)	11.3	13.4	8
F. (Special nursing)	5.3	2.4	1
III. High ADL* (7-8) Dependencies			
G. (Not hand fed)	8.0	10.3	11
H. (Not hand fed, but behavior problems)	10.2	14.1	8
I & J**. (Hand fed, includes those with severe behavior problems)	13.5	17.4	19
K. (Special nursing)	28.1	15.0	6

* ADL = Activity of Daily Living

** The distinction between Class I and J requires data on diagnosis. Due to problems with this data item in the California data set, we have collapsed the two categories.

Source: Lewin and Associates Resident Assessment Study, 1987; Minnesota Department of Human Services, 1986.

California, as indicated earlier, has a larger supply of residential care facilities than most other states. Some of the individuals who are ICF patients in other states may be in these residential settings in California. An important consideration for the state is whether or not residential facilities can appropriately accommodate these patients who might need a higher level of care than they generally provide. The state is currently considering a legislative proposal to create a new level of care within residential facilities for persons needing "health-related assistance" for whom the facility would receive an additional payment. This category is being defined for persons needing "extensive assistance with personal activities of daily living who also require occasional services of an appropriate skilled professional due to chronic health problems." The Department of Social Services estimates that about 10 percent of the current residential care population might fit this definition. Unfortunately, we do not have patient assessment information on the residential population and so cannot compare their care needs to the residents in California's nursing homes.

Inappropriate Placement in Nursing Homes Does Not Appear To Be a Major Problem

While difficult to determine in any definitive way, the state does not appear to have a major problem with patients being placed inappropriately in nursing homes. This should not, however, be taken to imply that all residents in nursing homes need to be there or could not be cared for in the community were appropriate support resources available. The state has had in place for a number of years a Treatment Authorization Request (TAR) utilization review system under which patients are assessed shortly after their admission to a nursing facility and periodically thereafter to verify their initial and continuing need for nursing home services. In calendar year 1986 the Medi-Cal field offices handled 87,000 initial requests for SNF or ICF care, of which 19 percent were modified and 1 percent denied. During the same

period around 79,000 reauthorizations were reviewed, of which 11 percent were modified and about one-half of one percent denied.

While drawing definitive conclusions is impossible, three factors suggest that not many Medi-Cal beneficiaries are in nursing homes who do not meet the criteria required for this level of care.

- The results of our Resident Assessment Study cited above indicates higher levels of patient acuity than in some other states from which data is available.

- The level of care needs of the Medi-Cal patients in nursing homes appears to have increased. While the assessment instruments and the sampling procedures were not the same, comparisons can be made on basic items between a 1980 Department of Health Services Study of patient needs and our 1987 Resident Assessment Study. For example, as shown in Exhibit 23, 77 percent of the patients in freestanding facilities in 1987 needed help in bed transfer, compared to 58 percent in 1980, and 43 percent required assistance in feeding compared to only 22 percent in the earlier sampling.

- The overall number of Medi-Cal patient days in nursing homes has not increased despite an increase in the number of elderly in the state. This suggests as we indicated earlier, that access to nursing home care for Medi-Cal patients may be more of a problem because it is unduly limited than because it is too open.

Exhibit 23

COMPARISON OF 1980 TO 1987 DATA ON ACTIVITIES OF DAILY LIVING (MEDI-CAL ONLY)

	1980			1987			
					Freestanding		
	Total	SNF	ICF	Hospital based	Total	SNF	ICF
Incontinent, Bowel							
Yes	41.3	42.3	27.5	39.8	39.9	63.3	11.1
Colostomy/ Ileostomy	N/A	N/A	N/A	1.7	1.5	1.5	0.0
Incontinent, Bladder							
Yes	47.9	49.0	32.0	33.5	35.6	57.3	18.2
Catheter	N/A	N/A	N/A	12.2	11.5	12.7	0.7
Needs any help with ADLs							
Bathing	92.8	93.6	82.0	96.7	97.5	97.6	93.2
Dressing	75.5	77.4	46.9	90.13	87.7	90.6	53.9
Bed transfer	57.6	59.0	37.5	77.9	77.3	81.8	18.6
Feeding	21.7	21.6	22.0	53.4*	43.5*	45.9*	16.8*

* Includes tube fed.

Source: Data Matters, Department of Health Services, 1980; Lewin and Associates Resident Assessment Study, 1987.

Disappointing Results of State's Preadmission Screening Program Are Difficult to Judge

The state continues to appropriately question whether all of the patients who could be maintained in the community if adequate resources were available are being identified and served. These are individuals who, while they would qualify for nursing home care, can be maintained in the community if the right mix of services were obtained. An Auditor General report in April 1984 reviewed the success that the San Jose Medi-Cal field office was having in diverting patients who were living in the community from placement in nursing homes. During FY 1982-83 in the San Jose office, 21 percent of the community referrals to nursing homes were diverted through preadmission screening by the social service consultant. The Auditor General's report noted programs in other states that were successful in maintaining individuals in the community through concerted preadmission screening efforts. At the time of the Auditor General's study, the Medi-Cal field offices had the authority to conduct preadmission screening but were not required to do so. Only the San Jose and the San Diego field offices had ongoing programs. Both the Los Angeles and Oakland field offices had tested the concept but terminated it on the grounds that it was not cost effective.

Convinced that preadmission screening had enough merit to warrant a full-scale test, the Legislature enacted AB 2684 (Chapter 213, Statutes of 1986) to require preadmission screening by all Medi-Cal field offices for all prospective placements beginning July 1, 1986, and a postadmission screening review of all residents in the facilities who entered before July 1, 1986. The Department of Health Services reviewed the results of the first six months of the statewide program in a March 1987 report that indicated that only 23 individuals had been diverted from nursing home placement out of nearly 30,000 that were subject to the preadmission screening. The results as reported by the Department of Health Services are summarized Exhibit 24.

Exhibit 24

REPORTED RESULTS OF IMPLEMENTATION OF STATE WIDE PREADMISSION SCREENING PROGRAM

	Preadmission Screening		Postadmission	
	From Hospital*	From Community	Screening	Total
Authorized for prolonged care	18,867	3,736	15,615	38,218
Authorized for short stay	4,995	1,248	14,996	21,239
Diverted/ discharged	14	9	0	23
Total	23,876	4,993	30,611	59,480

Most frequently noted services which could have been used if available and/or at adequate level:

	Number
• In-Home Supportive Services (IHSS)	4,594
• Multi-Purpose Senior Services Program (MSSP)	927
• Adult Day Health Care (ADHC)	264

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* 48% of these patients were residents of nursing homes prior to their admission to the hospital.

Source: Department of Health Services Report to the Legislature Regarding Preadmission Screening, March 1987.

The preadmission screening program did identify some services that might have been useful in allowing patients to remain in the community that

were either not available or not available in sufficient magnitude. The most important of these was In-Home Supportive Services (IHSS) where according to the Department of Health Services report:

> The reason that IHSS was not able to be used was that the IHSS maximum grant levels were not high enough to provide enough hours of assistance. However, for most cases the grant levels that could have supported diversion would have exceeded the cost of care in a long-term care facility.

As a consequence of the study's findings the Department recommended that preadmission screening for prospective nursing home admissions from hospitals be delegated to acute care hospital discharge planners. The Department argued that hospital discharge planners are aware of community resources and are already making all appropriate efforts to find alternatives in the community. The Legislature enacted AB 651, which will delegate the preadmission screening process to hospital discharge planners with review and monitoring by the Department. Field office preadmission screening will continue to be performed by the field offices for potential placements from the community.

Unfortunately, it is difficult to judge the results of the preadmission screening effort. Some consumer advocates argue that the Department's study results are misleading, believing that the field offices did not make an aggressive enough effort to find alternative placements. They contend that knowledgeable and experienced discharge planners may have sufficient information to find appropriate alternatives to nursing home placement, but that inexperienced individuals will not have the competence to do an effective job. Additionally, as pressures mount within hospitals to discharge patients earlier, because of the incentives under Medicare DRGs, the additional time it often takes to arrange a mix of community services will not be economically feasible for the hospital. While we did not review any of the backup documentation, it is unclear why the rate of diversions on the

community placements was so much lower in the full state program than in the earlier pilots in selected field offices. Even the Los Angeles field office that discontinued the program had an 11 percent diversion rate on community clients during its earlier test of the process.

Significant issues thus remain about where the state wants to place its emphasis in the development and funding of a full continuum of care for the elderly. Additional funding of services in the community and a commitment to care for individuals outside of nursing homes (even if the total expense is higher) could reduce the numbers of individuals in nursing homes. It appears that a more aggressive preadmission program will be needed to screen potential nursing home placement of community residents, if this is to be an effective mechanism of assisting individuals to remain in the community.

Special Needs of Heavy Care Patients Are Not Being Met

Under state law and regulations, the SNF level of care covers patients with a range of service needs. A facility receives the same rate of payment per day regardless of the amount of resources necessary to provide quality care to the particular patient. The facility has one staffing standard (3.0 nursing hours per patient day under the SB 53/AB 180 reform) no matter what the distribution of patient acuity and care needs is within the facility.

As was discussed in the sections on access and quality of care, California appears to have a subset of particularly heavy care Medi-Cal patients who have special problems in obtaining quality care because their needs exceed what facilities can provide under the single reimbursement rate for the SNF level of care.

Some states have adopted a case-mix approach whereby patients are grouped into categories according to the intensity of their care needs. Rates are then adjusted accordingly so that more dollars are available for treating those patients who require a higher level of care. California has recently established a subacute category for patients with very intensive needs who no longer need to be in an acute care hospital but who have special nursing needs above what can be routinely provided by a SNF.

In Chapter IV we discuss in greater detail the alternative of a full case-mix system. We do not recommend such an approach since there does not appear to be a wide enough diversity among facilities in California in the average level of care needs of their patients to warrant such a major change. But as indicated earlier in this chapter and expanded upon in Recommendation C in Chapter V, we do recommend the addition of a new special category of care and rates. We believe this is necessary to address the significant problem in access and potentially in quality of care for a subset of heavy care patients who do not meet the requirements of the current subacute category.

Conclusions

- While California has a very low proportion of ICF beds compared to other states, there is no indication that this poses major problems. To the extent that some individuals who might qualify for ICF services are in residential facilities, efforts should be made to ensure that these facilities can and are providing an appropriate level of care.

- We found no evidence of a problem of patients being placed in SNFs and ICFs who do not require nursing home care. Results of our Resident Assessment Study suggest that patients require more assistance now than in 1980. Further, the overall number of Medi-Cal patients in nursing homes has not increased. This

finding does not address the issue of how many of these individuals could receive appropriate care in the community if aggressive efforts were made to arrange the required mix of supportive services and/or if cost were not a factor. None of our work therefore should be interpreted to forestall efforts to develop a full continuum of care in the community so that individuals, while eligible for nursing home placement, would have sufficient community supports to remain at home if that is their desire.

- There is a special subset of Medi-Cal patients with very heavy patient care needs that because of the flat rate system have their access to care curtailed and the quality of their care potentially compromised. The current subacute category, as will be discussed further in Chapter V, is not broad enough to accommodate to the level of care needs of these patients.

F. EQUITY AMONG PROVIDERS CRITERIA: **The reimbursement system should accommodate legitimate differences among facilities in the cost of doing business.**

Facilities have a right to expect that legitimate differences in the costs of doing business will be recognized in the rates paid by the state. California divides the state by geographical region to recognize differences in input prices (largely wage rates) and by size to recognize differences in economies of scale. Each geographic/size category must have enough facilities in it to allow reasonable stability from year to year in the determination of the median of the class. Decisions on size and geography are thus related in that the intersection of the two create a class, e.g., having a large number of geographical categories limits the number of size categories that can be used and vice versa.

The state has a separate class for hospital-based as opposed to freestanding facilities even though both theoretically provide the same SNF level of care. Hospital-based units receive, on average, nearly three times the rate of reimbursement as do freestanding facilities. The issues of the reasons for the differences in the cost base between these two types of facilities and of the equity of the current rate differential are currently the subjects of hot debate.

Geographical Groupings Do Not Uniformly Reflect Differences in Wage Input Prices

Under the current system, separate rates are set for facilities within three geographical areas: Los Angeles County, Bay Area counties (Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara), and all other counties. If input prices that facilities face vary across these regions, one could argue that these differences should be reflected in the rates since the input prices are beyond the control of the facilities. Labor input prices, as measured by hourly wages, is one measure that is particularly relevant to nursing homes since expenditures on labor represent over half their costs.

As part of our analysis of 1985 cost reports, we examined the hourly wage rates paid by facilities within these three geographical groupings. As shown in Exhibit 25, the Bay Area counties do have a significantly higher hourly wage rate for both nursing and support staff, but the other two categories, Los Angeles and All Other, do not differ from each other.

Exhibit 25

WAGE RATES BY THE GEOGRAPHICAL GROUPINGS USED IN THE STATE'S RATE SETTING (1985)

	Nursing* Hourly Wage Rate	Support Staff Hourly Wage Rate
Los Angeles	$5.87	$6.10
San Francisco Bay Area (Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara)	$6.74	$6.62
All other	$5.88	$6.05

* This represents a blended rate of all nursing personnel including R.N.s, L.V.N.s, and nurse's aides.

Source: Lewin and Associates cost analysis.

We explored other ways of dividing the state into geographical regions that reflect differences in wage rates, are meaningful geographic units, and are of sufficient size to be used as a group for the purpose of setting medians or ceilings. A cluster analysis that combines counties into categories having similar wage rates was performed as part of our cost analysis. Two alternate divisions of counties based on the cluster analysis (one into four categories and one into six) are displayed in Exhibit 26. The resulting categories are either too small and/or lack geographical meaning.

Exhibit 26

CLUSTER ANALYSIS OF WAGE RATES BY CATEGORIES OF COUNTIES (1985)

Category	Counties	Wage Rate	
		Nursing	Support
	Four Categories		
1	All other		
2	Alameda	$6.49	$6.42
	Santa Clara	6.72	6.48
	Contra Costa	6.58	6.67
	San Francisco	6.85	7.03
3	Solano	6.08	6.87
4	San Mateo	7.53	7.01
	Mono	7.58	7.17
	Six Categories		
1	All other		
2	Sacramento	$5.85	$6.04
	Sonoma	6.02	6.04
	Mendocino	5.92	6.08
	San Diego	5.74	6.09
	Los Angeles	5.89	6.09
	Ventura	6.03	6.19
	Monterey	6.20	6.21
	Orange	6.26	6.22
	Riverside	5.84	6.28
	Santa Cruz	6.02	6.32
	Santa Barbara	6.33	6.32
3	Alameda	6.49	6.42
	Santa Clara	6.72	6.48
	Contra Costa	6.58	6.67
4	Solano	6.08	6.87
5	San Mateo	7.53	7.01
	Mono	7.58	7.17
6	San Francisco	6.85	7.03

Source: Lewin and Associates cost analysis (includes the 33 counties that have at least five nursing homes in the county).

Another analysis compared wage rates by Metropolitan Statistical Areas (MSAs). In this analysis we examined the nursing home wage rates from our cost analysis and the Medicare Wage Index that the Health Care Financing Administration (HCFA) constructs, based on wage rates in acute care hospitals, to weigh their DRG payments to hospitals. As can be seen in Exhibit 27, except for the three Bay Area MSAs there do not appear to be any other geographically meaningful clusters of MSAs on these two wage rate indices.

Exhibit 27
WAGE RATE VARIATIONS BY MSA (1985)

MSA	Counties	Standardized Medicare Wage Index	Medi-Cal Nursing Wages*	Medi-Cal Other Wages
San Francisco	San Francisco San Mateo Marin Santa Clara	1.4417	1.29	1.22
Oakland	Alameda Contra Costa	1.4893	1.15	1.12
Vallejo/Fairfield	Napa	1.3397	1.08	1.10
Sacramento	El Dorado Placer Sacramento Yolo	1.2969	1.02	1.04
San Jose/ Santa Clara	Santa Clara	1.2922	1.19	1.12
Los Angeles/ Long Beach	Los Angeles	1.1600	1.04	1.06
Santa Rosa	Sonoma	1.1445	1.06	1.05
San Diego	San Diego	1.1438	1.02	1.06
Anaheim/Santa Ana	Orange	1.1012	1.11	1.08
Riverside/ S. B.	Riverside San Bernardino	1.0925	1.00	1.07
Chico	Butte	1.0878	0.98	0.98
Santa Cruz	Santa Cruz	1.0851	1.06	1.10
Modesto	Stanislaus	1.0564	0.97	1.00
Bakersfield/Kern	Kern	1.0525	1.05	0.98
Santa Barbara	Santa Barbara	1.0925	1.12	1.10
Fresno	Fresno	1.0029	1.02	0.98
Napa	Solano	NA		
Oxnard/Ventura	Ventura	1.2851	1.07	1.07
Merced	Merced	NA	0.98	0.95
Redding	Shasta	1.2396	0.96	1.00
Salinas/Seaside/ Monterey	Monterey	1.2871	1.10	1.08
Stockton	San Joaquin	1.2871	1.05	1.02
Visalia/Tulare/ Porterville	Tulare	1.0643	0.98	0.99
Yuba	Sutter Yuba	1.0460	1.04	0.98
Rural	(21 counties)	1.0000	1.00	1.00

* Standardized to 1.0 for the non-MSA counties.

Source: Lewin and Associates cost analysis.

Based on these analyses, we believe that the current Bay Area geographical category should continue to be used. Los Angeles, while not different in wage rates, has a large enough number of facilities that treating it as a separate category is an acceptable but not necessary part of the rate-setting process. We understand that the Department of Health Services will be exploring the issue of geographical groupings in greater depth during the current year.

Facility Size Groupings

As can be seen in Exhibit 28 costs per patient day in SNFs are higher in the 1-59 bed than the 60-299 bed facilities. The 1-59 bed facilities have higher total costs per patient day and spend less per patient day on property and more per patient day on all other cost components. The results of a multiple regression analysis suggest that the lower costs in larger homes may in fact be the result of economics of scale in larger homes. We correlated the size of homes with costs for each cost category, controlling for geographic location. We found that size was significant (in the statistical sense) though modestly associated with lower costs for all cost centers except property, education, and housekeeping.

The changes we are recommending in the basic rate methodology may make the need for size categories less important (since it is more facility-specific). But based on the information reviewed, we have no reason to recommend a change from the current size categories.

Exhibit 28

AVERAGE COSTS PER PATIENT DAY BY COST CENTER AND SIZE

	Facility Size		
Cost Category	60 Beds	60-299	300+
Nursing	$25.06	$21.04	$26.55
Dietary	7.49	6.06	7.74
Social Work	1.15	0.82	1.21
Education	0.06	0.04	0.06
Plant Operations	3.74	3.10	4.26
Housekeeping	2.34	2.17	2.92
Laundry	1.64	1.37	1.89
Property	5.04	5.39	4.13
Administration	8.11	6.81	6.22
Total Direct Care	33.34	27.88	35.57
Total Other Costs	20.86	18.81	19.42
Total Costs	$54.19	$46.69	$54.98
Number of facilities in size class	325	625	5

The Use of Size and Geography Classes for ICF Facilities Results in Excessive Fluctuation of the Rates

The small number of facilities with ICF beds makes the use of both size and geographical categories an unwise practice. Exhibit 29 displays the small number of facilities within each category.

Exhibit 29

NUMBERS OF FACILITIES IN ICF CATEGORIES
(1987)

Size	Geographical Region			
	Los Angeles	Bay Area	Other	Total
1-59	13	15	46	74
60-299	7	2	5	14
	20	17	51	88

Source: Department of Health Services Rate Studies.

Not surprisingly, because there are so few facilities in some of these categories there are wide fluctuations in the rates from year to year, as shown in Exhibit 30. The number of facilities in some of the categories is too small to warrant the use of a median as a rate or ceiling.

Exhibit 30

VARIATIONS IN RATE INCREASES IN ICF CATEGORIES

Geography & Bed Size Category	Percent Change in Rate from Prior Year				
	FY 83	FY 84	FY 85	FY 86	FY 87
Los Angeles 1-59	12.3	0	12.3	(-10.7)	(-9.0)
Los Angeles 60-299	0	8.4	0	0.3	1.6
Bay Area 1-59	3.7	5.3	15.1	(-7.8)	2.5
Bay Area 60-299	0	4.9	2.9	12.0	(-2.0)
Other 1-59	1.2	9.4	1.3	0	4.7
Other 60-299	0	4.3	15.6	6.2	(-6.9)

Source: Department of Health Services rate studies.

Differences Between Hospital-Based and Freestanding Facilities

An Office of Statewide Health Planning (OSHPD) study on FY 81-82 data indicated that about 30 percent of the difference in expenditures per day between hospital-based distinct part and freestanding facilities was accounted for by nursing costs: a combination of more hours and higher wage rates. As will be discussed further in Chapter V, our cost analysis on 1985 data confirmed the finding that the hospital-based units provide more nursing hours per patient day and pay higher wage rates.

Our Resident Assessment Study indicated that hospital-based units have a higher case mix, i.e., patients with an overall higher level of acuity. Patients in the hospital-based unit also receive more "special nursing treatments." These data indicate that there are some real differences in the types of patients and in the services rendered in hospital-based units.

As will be seen in our more extensive discussion of these issues in Chapter V, not all of the differential in costs, however, is the result of variations in patient mix, services rendered, or wage rates. A substantial portion of the difference results from the higher property and indirect expenses that are assigned to the nursing home unit in a hospital. The OSHPD study found that "indirect expenses" were twice as high in hospital-based as freestanding units and our cost analysis showed that property costs per patient day were three times as high and non-nursing, non-property costs were nearly five times higher in hospital-based than freestanding facilities.

The rates to be paid to hospital-based distinct part units in FY 87-88 are in many cases above the Medicare allowable cost limit. Based on recently released Health Care Financing Administration (HCFA) regulations, the state hospital distinct part SNF units may be prohibited from receiving more than the allowable Medicare limit.

The hospital distinct part separate rate was originally designed to maximize federal participation under Medicaid for state hospital and county owned distinct part units. The number of private hospitals that have opened units in the last two years has increased dramatically, as was shown in Exhibit 6, and this trend is likely to continue. These newer units tend to be more costly and their addition to the class may result in sizeable increases in the median rate for the class in subsequent years.

Conclusions

- The use of Los Angeles as a separate SNF geographical category is not necessary, since their wage rates (as a proxy for input prices) do not appear to differ from the "All Other" category. Because there are so many facilities in the Los Angeles category, however, it does not create a distortion in the rates to retain the class. The continued use of a Bay Area category is warranted.

- There is no reason to alter the current SNF size categories, although the importance of size may diminish under our recommended new system that is more facility-specific.

- There are not enough ICF facilities to justify the use of six separate geography and size categories. As a result there is more variation in rate changes from year to year than is appropriate.

- Some of the difference in the costs of hospital-based distinct part and freestanding facilities is accounted for by differences in patient acuity, the amount of services rendered, and wage rates. However, a significant portion of the difference occurs because of property and indirect expense items. Further, in some cases the hospital-based rates appear to be above the Medicare allowable limit.

G. <u>ADMINISTRATIVE FEASIBILITY CRITERIA</u>: The reimbursement system should not require a large administrative cost to implement with accuracy and timeliness.

The current reimbursement system is being implemented with low administrative costs. But because the flat rate system does not require accuracy at the specific facility level there has not been sufficient attention paid to the administrative actions that would be necessary to ensure the consistency and validity of the cost information received from the state's nursing homes. (These problems were described in the section on Accountability.)

The Legislature, through the labor passthrough, has added a facility-specific mandate to a system that cannot easily provide accurate information by facility and which is not designed to ensure compliance with reporting requirements at the facility level.

Implementation of the Labor Passthrough Has Been Time Consuming and Complex

The labor passthrough, as described under the section on Quality of Care, requires facilities to certify that they have used the particular component of the funds received from Medi-Cal to increase expenditures on nonadministrative personnel in conformance with the specific legislation or budget language. The Department of Health Services Audits and Investigations Unit reviews facility records to verify compliance at the same time that they perform the annual rate audits on an approximate 15 percent sample of the freestanding nursing homes. When problems are found they are referred to the Accounting Division of the Department of Health Services for recoupment to the Medi-Cal budget or to the Labor Commissioner for recoupment and dispersion of funds to individual employees. The process is costly, difficult to understand, and not well coordinated or monitored.

As of August 3, 1987, the Audits and Investigations Unit had completed audits of 209 facilities for compliance with the 1985 SB 53/AB 180 requirements. The law contained two requirements: to augment wages of all employees by a set amount (a requirement of Welfare and Institution Code Section 14110.6) and to increase overall spending on nonadministrative personnel by a set amount either by increasing staff or wages or both (a requirement of Section 14110.7).

The Audits and Investigations Unit has summarized the results of its initial audits, but the findings are difficult to interpret since the unit has not established specific guidelines for the auditors to follow in making an overall judgment of whether or not a facility is in compliance. The summary reports that 32 percent of the facilities were not correctly passing on the Code Section 14110.6 funds and 26 percent were not spending the Code Section 14110.7 funds. Total amounts of the errors which would qualify for

efforts to recoup funds amounted to $458,000. The Audits and Investigations Unit estimates this to be about 11 to 12 percent of the total augmentation amount available to these 209 audited facilities. The audit period covers the first few months of the 1985 augmentations so that some of the errors might be the result of the requirements not yet being fully understood.

The Department of Health Services refers cases to the Labor Commissioner and to the General Collections Unit of the Accounting Division within the Department for recoupments. The former receive cases where funds are due to individual employees and the latter where the facility has not met a global test of spending a set amount to increase overall expenditures on nonadministrative labor. It is difficult to track the recoupment process since no one agency has responsibility for monitoring what happens with each case. The data we received from the Labor Commissioner and the Department's General Collections Unit about successful recoupment do not therefore correspond to the information from the Audits and Investigations Unit about amounts to be recouped.

The Labor Commissioner has assigned responsibility for recoupment to its northern and southern regional Bureaus of Field Enforcement. For the period from January 1, 1986, through mid-1987, these two offices collected $104,300 in recoupments and $13,800 in penalties from 43 facilities. They do not keep track of how many cases are outstanding. They follow their standard procedures with these claims, and the chiefs of both units report their collection rate is good even though the nursing home labor passthrough cases are not a high priority within their Bureaus.

The General Collections Unit within the Department of Health Services does not track wage passthrough recoupments specifically but can document how much has been recouped in a case type that a Unit representative reported is predominantly labor passthrough. In FY 85-86 they opened 36 new cases for $468,000 and in FY 86-87 they had another 90 new cases for $274,000. Amounts

collected in those two fiscal years were $26,000 in FY 85-86 and $15,000 in FY 86-87. Again, the years' activity in case openings and collections are not comparable, making conclusions about recoupment difficult. As of the end of August 1987, the unit reports 46 cases outstanding for a total of $443,000. If a facility fails to repay funds owed voluntarily, the General Collections Unit can have the Fiscal Intermediary reduce payments to the facility until the funds are recouped.

The audit process for the labor passthrough is so complicated that for the first few months of activity in FY 1987-88 the Audits and Investigations Unit has been using as much time for the labor passthrough audit (148 hours) as for the regular rate audit of the cost report (136 hours). The audits of the AB 180/SB 53 certifications reviewed during FY 1986-87 took an average of 92 hours each. The audits for the current year are requiring the additional hours (the 148 hours) since they must also include an audit of the requirements from the Budget Act control language.

As a consequence of the resources needed to audit for the labor passthrough, the Audits and Investigations Unit plans to audit only 60 facilities in FY 87-88 or about 5 percent of the total facilities. Whatever noncompliance occurs in the remaining 95 percent of the facilities that are not audited will not be subject to recoupment.

Conclusions

Because the flat rate system does not require attention to accuracy of individual cost reports, the administrative systems surrounding accounting, reporting, auditing, and enforcement have not been well developed. So while the current system is administratively simple, any effort to ensure accountability at a specific facility level, e.g., the labor passthrough, creates requirements that are not easily handled within the current administrative structures and processes. The labor passthrough has been time

consuming to audit and complex to implement. The amount of time required to audit what are now five separate labor passthrough requirements exceeds that required to conduct the rate audit, so therefore the number of planned labor passthrough audits has had to be reduced. There is a process for referral of cases for recoupment but no one has the responsibility for monitoring the outcome of the referrals.

H. SIMPLICITY CRITERIA: The reimbursement system should be easy to understand.

The basic concept of the prospective flat rate system organized by geographical area, bed size, and level of care classes is easy to understand. The state can project its expenditures, legislators are aware of the basic approach, and facility operators know generally what they can expect to receive for Medi-Cal patients.

As indicated above, however, efforts to use the reimbursement system to enhance other policy objectives such as encouraging spending on patient care related items create substantial complexity. This is because the basic flat rate methodology is not designed to accommodate targeting of funds, such as is required by the labor passthrough.

Conclusions

The basic approach of the current system satisfies the simplicity criteria, but continuing concern by the Legislature to target rate increases to specific quality of care enhancements will create substantial complexity if the current flat rate approach is maintained.

CHAPTER IV: OPTIONS SPECIFIED FOR CONSIDERATION IN THE RFP

The RFP identified three specific reimbursement options to be considered in this study:

- "Cost center" reimbursement,
- "Case mix," and
- "Outcome-based."

This chapter describes our analysis of the latter two options, ones we do not recommend.

A. COST CENTER REIMBURSEMENT

Cost center reimbursement refers to systems that establish different methodologies and strive for different incentives, with respect to different components of nursing home expenditures.

We considered this option and, for reasons described in the following chapter, recommend it.

B. CASE-MIX REIMBURSEMENT

The term "case-mix reimbursement" describes a reimbursement system in which rates vary with the differing care needs and services provided to nursing home residents: facilities receive higher rates for providing care to residents whose treatment is more resource intensive.

At present, California has in practice a five-tiered residential/ institutional long-term care system: residential care, ICF, SNF, hospital-based SNF, and subacute. Our Resident Assessment Study did not include residential care facilities or subacute care patients but, as demonstrated in the table below, the average "case mix" or acuity of patients did vary in the expected direction with respect to the levels of care recognized by the Medi-Cal reimbursement system.

Exhibit 31

AVERAGE "CASE MIX" OF MEDI-CAL RESIDENTS, BY LEVEL OF CARE

Level of Care	Average Case-Mix Score*
ICF	1.97
SNF - Freestanding	2.62
SNF - Hospital-based	2.86
Subacute	NA

* Derived from the Lewin and Associates Resident Assessment Study, 1987.

The case-mix scoring system we used (based on the Minnesota system) ranges from 1.00 (the lightest care) to 4.12 (the heaviest care). A score of 4.12 means that the resident is 4.12 times as "costly" to care for with respect to nursing as the lightest care resident. We found ICF residents with scores from 1.00 (29.0 percent) to 2.56 (4 percent), and SNF patients with scores from 1.00 (7.2 percent in freestanding and 6.2 percent in hospital-based) to 4.12 (13.7 percent in freestanding and 26.5 percent in hospital-based). All freestanding facilities are paid essentially the same rate for providing care to these patients.

As discussed in the following chapter, we are recommending three system changes to better match Medi-Cal reimbursement to the care needs and services provided to Medi-Cal residents: a cost-component system that pays more for direct care items to facilities that spend more on these cost components; an expanded "Special Care Class" rate for those at the high end of the SNF class (but who do not qualify for the subacute rate); and a new hospital-based limit that recognizes the differences in patient acuity of residents in that setting compared to freestanding facilities, but which mitigates the overstatement of differences in the current rate differential.

We are not, however, recommending that California adopt a full-scale case-mix reimbursement system at this time for two key reasons. First, there is relatively little difference among freestanding SNF facilities in average case mix; second, there appears to be considerable skepticism about the feasibility of introducing a system that would require serious assessments of resident care needs at least once a year. These are discussed below.

Lack of Extreme Variation in Average Case Mix

We found relatively limited variation among freestanding SNFs with respect to average case-mix score or patient acuity, suggesting that California nursing homes have reached some accommodation with the flat rate system over the years. As can be seen in Exhibit 32, the average case-mix score of the facility at the 10th percentile was 2.32, while the average case-mix score of the facility at the 90th percentile was 3.13.

Exhibit 32

DISTRIBUTION OF FREESTANDING SNFs BY AVERAGE CASE-MIX SCORE*

Cumulative Percent of SNFs (Beginning with Facility with Lowest Case-Mix Score)	Range of Case-Mix Scores (Lowest to Highest)
Lowest 10 percentile	1.3 - 2.32
10 - 24 percentile	2.32 - 2.53
25 - 49 percentile	2.54 - 2.74
Median facility	2.75
51 - 74 percentile	2.75 - 2.92
75 - 89 percentile	2.93 - 3.10
90 - 100 percentile	3.13 - 3.77

* Based on 1987 California Resident Assessment Survey. This table includes the 134 facilities from which there were sufficient data to compute an average case-mix score. The scoring system used is the Minnesota case-mix weighting system.

Those data indicate that 80 percent of facilities have an average patient acuity within a maximum range of 35 percent difference between the highest and the lowest (3.13 is 35 percent higher than 2.32). In other words, the 90th percentile facility has residents who are on average about 35 percent more costly to care for with respect to nursing as the residents in the 10th percentile facility. Since nursing costs comprise about 40 percent of total expenditures, the case-mix data suggest that for 80 percent of freestanding SNFs, a case-mix system would only provide for more finely tuned rates to

account for an expected 14 percent (35 percent of 40 percent) variation in expenditures; other differences in expenditures would not be impacted by a case-mix system.

The observed variation among facilities in actual nursing expenditures considerably exceeds the variation in case mix. Thus, it is not surprising that we found a statistically insignificant and, in practical terms, negligible association between facility case mix and nursing expenditures per patient day. This means that developing a reimbursement system that took case mix into account in terms of setting limits or rates for the nursing expenditure portion of the rate would do very little to enhance the equity of the payment system.

It might be argued that if most facilities have residents who are relatively similar (on average) with respect to <u>care needs</u> ("case mix"), then it is equitable to pay all facilities about the same. While true to some extent, this vision of equity overlooks variations among facilities in the <u>actual care</u> being provided -- the most reliable measure of which is actual expenditures. Thus, as discussed in the next chapter, while we do not recommend a case-mix system on the grounds of enhancing equity and quality of care, we are recommending other changes that entail moving away from a flat rate system to a facility-specific methodology that rewards higher actual expenditures on patient care activity.

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* For the correlation between average case-mix score (Medi-Cal and other payers) and nursing expenditures per day, R^2 equals .1964, indicating that less than 4 percent of the variation in nursing expenditures can be "explained" by case-mix score. It should be noted that expenditure data are from 1985 and case-mix data are from 1987.

Considerations Regarding the Feasibility of a Case-Mix System

Case-mix systems can be a powerful tool to promote access for heavy care residents, and we found that California does have a problem in that regard. In order to deal with a serious "access for heavy care residents" problem through the general reimbursement system, however, the case-mix system needs to pay rates to facilities that are very sensitive to changes in case mix. In brief, to address California's most apparent problem with regard to case mix (access for heavy care residents) through the general reimbursement system would require a system with timely and frequent assessments of all patients.

In considering the feasibility of a case-mix reimbursement system for California, we interviewed state personnel, providers, and other knowledgeable observers. We found considerable skepticism about the feasibility of building a system that required periodic serious assessments of residents to which the rates would be tied. Providers were concerned that if the Medi-Cal Field Offices were responsible for the assessments, such assessments would by definition be done by persons not intimately familiar with the residents. Some observers were concerned that if facility personnel were responsible for the assessments it would be virtually impossible to control "gaming." Some state personnel thought it all sounded simply too complicated for so large and diverse a state as California.

We are not convinced that such skepticism is fully warranted. For example, there was close agreement during the Resident Assessment Study in this project between the assessments provided by facility staff and the validation checks provided by Medi-Cal field staff. In general, both providers and Medi-Cal staff demonstrated during the study the clear capacity to undertake serious assessments of a very large number of residents on very short notice. Similarly, the large size of the California system per se does

not make a case-mix system infeasible, as demonstrated by the successful implementation of the New York system. Finally, both the New York and Minnesota systems have features that severely limit facilities' ability to profit by "gaming" the assessment system, and such design features could be incorporated into a case-mix system for California.

On the other hand, implementing a full-scale case-mix reimbursement system in California would be an undertaking of considerable magnitude requiring substantial administrative resources and commitment. After reviewing the evidence, we concluded that the gain to be achieved by such a system does not at this time warrant the resources that would be required. Instead, we have developed alternative recommendations to address identified problems, particularly those of the heavy care Medi-Cal patient.

C. OUTCOME-BASED REIMBURSEMENT

By "outcome-based" reimbursement, people generally mean associating a portion of a facility's reimbursement to "quality of care," in terms of measurable patient "outcomes." At one rather gross level, all Medicaid reimbursement systems, including California's, tie reimbursement to quality of care and outcomes: facilities that fail to meet minimum standards and exhibit egregious outcomes are decertified; facilities can be and are fined for various violations of quality standards.

Many people are dissatisfied with this "negative" approach to quality assurance, and we were asked to consider the possibility of California's developing a system that included positive financial rewards for good "outcomes" or at least for better quality care. We believe that the recommendations discussed in the next chapter will move California in the direction of a closer linkage between Medi-Cal rates and services provided. We do not recommend that California attempt to develop a more refined outcome-specific reimbursement system for the reasons discussed below.

Lack of Appropriate Technology to Assess the Cause of "Outcomes"

The technology to distinguish fairly and systematically between patient outcomes attributable to facility "effort" and other factors (e.g., patient "effort" or lack of effort) does not exist. Dr. Robert Kane (currently at the University of Minnesota, previously at Rand) has devoted considerable effort to studying the normal (expected) outcomes of residents in nursing homes in the hopes that a reimbursement system that rewarded facilities for better than expected outcomes could eventually be developed. These data show extreme fluctuations in outcomes (unexplained variations), suggesting that only with very large samples could norms ultimately be developed. Even if norms for large numbers of residents could be developed, the number of residents cared for by an individual facility would be relatively small, making it very difficult to determine whether a facility's deviation from the norm in terms of resident outcomes was due to lack of care or random statistical variation.

Negative Consequences of an Effective Outcome-Based System

A number of observers believe that the technical difficulties inherent in developing an outcome-based reimbursement system can ultimately be overcome. The federal government, for one, continues to support research in this area. While the lack of an appropriate technology makes the issue with regard to an immediate system change in California moot, we would like to raise some non-technological concerns presented by Willemain in a thoughtful paper commissioned by HCFA in 1980 entitled "Second Thoughts About Outcome Incentives for Nursing Homes."

Willemain argued that even if outcome-based reimbursement were technologically feasible, it would be undesirable because the anticipated

market response (good homes driving out bad homes) would not occur, the system would be highly cost-inflationary, and such a system could endanger quality of care.

Arguing against the prospect that outcome-based reimbursement would result in the market responding with good homes driving out bad, Willemain notes that:

> In light of the growth of the elderly population and the human problems occasioned by the closing of facilities, the stated goal of driving inferior nursing homes out of business has little to commend it over the alternative of upgrading those facilities, if that could be accomplished . . . If poor homes left, would good new homes enter the field? Historically, a major non-demographic force for growth in the nursing home industry has been the certainty of reimbursement. Yet outcome reimbursement can hardly avoid making the industry look more risky.

A consequence of an increased perception of risk would likely be a requirement for greater profit opportunities, leading to higher expenditures, which would only be warranted if the added perceived risk were commensurate with improved outcomes. As Willemain notes, however, "It is difficult to inspire trust with the assurance that government analysts will work out perfect formulas to balance the contingencies involved in individualized outcome reimbursements."

Finally, Willemain raises two problems with respect to quality of care. First, he suggests that directly tying reimbursement to a patient's "potential" could lead to a greater tendency than now exists for facilities not to choose patients whose course of care is suspected might be long and disappointing. Lastly, he raises the thorny issue of which outcomes, precisely, a reimbursement system should reward.

As we noted in an earlier chapter of this report, "quality" is difficult to reward explicitly because reasonable people disagree with respect

to how different aspects of quality should be weighed (e.g., good medical outcomes versus quality of life). This is less important if one is considering a modest reward system based on a facility's overall score in a "quality rating scale" like the QUIP program discussed below. The issue raises really troublesome concerns, however, when a system that might pay facilities on the basis of individual outcomes is contemplated. To cite Willemain again:

> [Outcome reimbursement] will make more acute a dilemma always present in third party reimbursement: the conflict between the preferences of the service recipient on the one hand and the payer on the other. True market enthusiasts would prefer some sort of cash payment or at least a voucher system, so that residents could shop for the style of care they desire. In contrast, outcome reimbursement would institutionalize centrally determined values in a powerful way. The choice of emphasis among the physical, psychological and social dimensions of care would serve as more than a model system of values, since deviance would threaten institutional collapse through withdrawal of funding.

Experiments with Incentive Payments Have Been Disappointing

As part of the nursing home reimbursement experiment conducted in San Diego from 1980 to 1983, researchers established protocols under which experimental facilities could receive additional payments for achieving selected outcomes such as healing a decubitus. Facility personnel could select which patients, if any, they wanted to enroll in this aspect of the experiment and to establish a goal for these patients. Nurses who were members of the study team selected patients in control facilities to match as closely as possible the experimental patients.

The results of the experiment were disappointing. There was very little difference in patient outcomes between treatment and control facilities. In some cases (e.g., decubitus care) control facilities did better in producing desirable outcomes than did experimental facilities.

In follow up studies the researchers found that study participants did not fully understand how the incentive payments were supposed to work. Furthermore, the directors of nursing and administrators who participated recommended that incentive payments not be adopted as part of the reimbursement system.

An objection frequently heard from nursing staff with regard to the notion of direct payments for specific clinical outcomes is that professional ethics make "trying your best" on all patients, all of the time, normative if not always achievable or realistic. Good nursing, it is said, can be identified by nursing supervisors and should be rewarded financially through higher wages, benefits, and working conditions. Nursing staff often object to the idea of selecting only certain patients and conditions for particular rewards; while the nursing ethic demands that the "most care" should be given where there is the "greatest need."

Financially rewarding a facility and its staff for overall good performance would overcome the above objection. The state program that comes closest to doing that is Illinois, which established a quality incentive program or "QUIP" two years ago.

The QUIP program allows facilities to elect to be rated in one or more of five quality areas: environment (the physical plant), participation, community integration, resident satisfaction, and patient care. Facilities that receive a high score in one area can receive an additional 50¢ per day; five-star facilities receive an extra $2.00 per day.

The state has received a grant to evaluate the program; judgment should obviously be withheld until that is available. At present, reaction is mixed. On one hand, several providers and other people in the state who are knowledgeable about the QUIP program, express considerable concern and

disappointment about its operation. The primary objection cited by some is the "arbitrary subjectiveness" of the rating system and its implementation. As we understand it, one provider association has requested that the program be discontinued and that monies be re-directed to improve quality of care.

On the other hand, state sponsors recognize the need to continue to improve the uniformity and objectivity of the rating process. Program enthusiasts believe that the rating form itself is serving an important teaching function. When Illinois filed its successful 1986 application for a Ford Foundation evaluation grant, the state described it as follows:

> The single most important achievement to date has been the development of resident care plans that have measurable goals which identify specific staff activities to assist residents in achieving these goals. Facility staff have also realized that geriatric residents can meet goals, can improve their functioning ability, and can learn to take care of themselves better than they did the day before. Up to now, most facilities operated under the assumption that older people deteriorated due to advancing age and that little could be done to retard or prevent the deterioration. Staff in facility after facility have become exhilarated in this realization and have begun working with residents to rehabilitate those residents. In fact, some facility staff state that the satisfaction of seeing residents improve has become a stronger motivating factor than the QUIP financing incentive.

The final sentence of the above quotation appears to reaffirm the notion that financial rewards directly tied to specified quality outcomes or objectives are not at this time the best approach to improving quality of care. A different, innovative model that bears watching is that currently under development in Wisconsin.

A Wisconsin task force consisting of representatives from the state industry and other interested parties has recently completed development of a detailed facility quality assessment protocol. As in Illinois, Wisconsin

facilities may voluntarily agree to be rated. A key difference, however, is that the assessments will be done not by the state but by independent surveyors supervised by the respected hospital survey organization, the Joint Commission for the Accreditation of Hospitals (JCAH). We recommended that California follow the implementation of the Wisconsin system and consider again next year whether that model might be suitable for California.

CHAPTER V: RECOMMENDATIONS

INTRODUCTION

We recommend that the Medi-Cal rate-setting system be revised, as detailed below, in order to better meet state goals. The system changes we propose are designed to address the problems described in the Chapter III, while minimizing unnecessary complexity and disruption.

In addition to proposing changes for the near future, we recommend that California continue to monitor key problem areas such as access to care by Medi-Cal beneficiaries and plan for potential further system modification, particularly with respect to the reimbursement of the capital cost component.

A. RATE-SETTING FOR FREESTANDING FACILITIES

Overall Recommendation

The state should adopt a facility-specific cost centered reimbursement system for its freestanding SNFs and ICFs. Such a system can maintain substantial cost control and at the same time ensure that profits derive from efficient operations in areas less related to direct resident care rather than from the lowering of spending on care-related items that have a more immediate impact on quality of care.

Two Different Cost Components Should be Established and Each Should be Treated Differently

As discussed in an earlier chapter, the current reimbursement system emphasizes incentives for cost containment by permitting facilities to keep the entire difference between what they spend and the rate they receive. Although this system may have retarded the growth in expenditures over time, it has also resulted in the state paying profits to some facilities that spend very little, on nursing care for Medi-Cal patients. As indicated in Chapter III, there is an inverse relationship between the extent of profit on Medi-Cal patients and the amount spent per day on patient care related items, i.e., those with the greatest positive margins spent the least.

In order for the state to better achieve the competing goals of cost containment and quality (i.e., paying for expenditures targeted on resident care), we recommend the development of a facility-specific reimbursement system that splits costs into two broad categories - "direct resident care" and "other" - and treats each differently.

In the "direct resident care" category, we recommend that California include nursing, dietary, social services, and training costs. The prospective rate for this component would be that facility's actual expenditures from a prior year, trended forward up to a limit or maximum level that would be set at a relatively high level such as the 70th or 80th percentile.

We recommend that the residual category "other" (e.g., property, maintenance, laundry, administration) have a lower limit than the direct care component. The prospective rate for this component would be the facility's actual expenditures from a prior year, trended forward, to the limit. We recommend that a substantial "efficiency incentive" or opportunity to profit by keeping expenditures low, be permitted on this component. For example, one

could set the limit for the "Other" category at the median and allow facilities below the median to be paid their costs plus half the difference between their costs and the median.

We recognize, of course, that both laundry and maintenance, for example, are important to resident care and that facilities that spend heavily on nursing may be inefficient. The proposed system is recommended as a means of balancing the incentives for cost containment and regulated expenditures. It should be noted that the proposal creates no stronger incentives to "scrimp" on laundry and maintenance than are present in the current system, and that inefficiencies in direct resident care will be discouraged both by the limits and our proposal regarding rebasing, discussed below. In addition, inefficiency is discouraged (in both the current and proposed systems) by the presence of private payers, since the more efficient the facility, the greater the profit on a private pay patient.

All Rates Would be Reset Every Third Year in a Rebasing of the Whole Rate System

Prospective facility-specific cost based systems can provide less cost control than the current flat rate system since increases in a particular facility's cost in the current year become the base for its subsequent rate. This problem can be greatly minimized by not rebasing costs annually. We recommend, therefore, that California rebase rates for most facilities not more often than every three years. In the interim years, each facility's rate would be its prior year's rate, trended forward by an appropriate inflation index. Under this proposal, a facility effectively faces its own flat rate for a three-year period and has an incentive in the short run to constrain expenditure growth.

While the three-year rebasing is important for controlling costs, it may be too strong a disincentive for certain low expenditure facilities.

Thus, we propose that facilities in the lowest quartile of expenditures per patient day on the direct care component would have their rate adjusted annually to encourage more investment in these areas.

The system also needs to protect against facilities that, faced with the equivalent of a three-year flat rate, decide to severely cut expenditures on the direct resident care component in order to increase their profits. Thus, we further recommend that the rate be readjusted for any facility whose reported expenditures on the direct care component falls more than 10 percent below what was projected in its rate to prevent a continuation of profit on items related to quality care. We suggest exploring the possibility of recouping any such decreases on patient care related expenditures. While this may increase administrative costs it should remove the incentive for attempting to make even a one year profit in the area of patient care related expenditures.

All facilities should have the opportunity of requesting a rate adjustment if they can document a significant change in their operations such as a major addition to the facility. The state will need to develop guidelines to use in the review and evaluation of these applications for rate adjustments.

The Recommended System Can Be Designed to Meet any Desired Total State Expenditure Targets

The new system could be designed to be budget neutral in the base year through the setting of the specific ceiling in direct care expenditures and the extent of the efficiency incentive. Because assumptions about the audit adjustments appear to have a substantial impact on estimates of costs and rates, we recommend that decisions regarding the precise setting of these parameters be deferred until the state has a set of seriously audited cost reports.

We simulated the base year costs of the proposed system using 970 SNF 1985 cost reports and the following assumptions:

- No audit adjustment (this is the most conservative assumption because any audit adjustment would reduce costs).

- Maintainence of the existing three geographic groupings but use of only two bed size categories: 1-59 and 60+.

- Direct resident care component limits set at the 80th percentile of each size/geographical group. Rates for the direct care component are the lesser of costs or the limit.

- Limits for the "other" category set at the median. Rates for the "other" category are costs to the limit, plus one-half of the difference between the facility's cost and the limit for those facilities with costs below the limit.

We found that under the above assumptions, the recommended system would cost the Medi-Cal program 3 percent less than the current system. Thus, for all practical purposes, the parameters outlined above produce a system that is approximately budget neutral.

We also examined the impact of the proposal on facilities, assuming (for the exercise) that there was no phase-in or special transition rules. We found that 52 percent of facilities would have rates at least $1.00 per patient daylower than under the current system, while 20 percent would have rate increases of $1.00 or more. It should be emphasized that the results of this simulation should not be construed as recommending that California reduce rates for nursing homes. The absolute level of reimbursement is discussed in Chapter VI. Rather, these simulations illustrate that at the same level of

expenditure, California could afford to pay for considerably more direct patient-related care. Under the simulation, virtually all facilities that currently have rates higher than costs would still make a "profit" on Medi-Cal residents, though for many the positive margin would be smaller. As indicated in Exhibit 33, below, facilities that currently take a smaller proportion of Medi-Cal patients would be likely to have rate increases. Again, it should be noted that we are not recommending, for example, that facilities with 75 percent or more Medi-Cal residents should have rate reductions "on average" (i.e., the median facility) of $1.42/day. These simulations illustrate the relationship between rate changes and type of facility, and indicate a starting point for discussions regarding final parameters.

Exhibit 33

DISTRIBUTION OF CHANGES FROM CURRENT RATE TO "NEW" RATE FOR FACILITIES BY PROPORTION OF MEDI-CAL PATIENTS

Rank of the facility from those with greatest rate reductions to least	% Medi-Cal Residents				
	0-25%	26-50%	51%-75%	75%-100	All Facilities
10 Percentile	(-$2.12)	(-$3.67)	(-$3.62)	(-$4.11)	(-$3.79)
25 Percentile	(-$2.02)	(-$2.01)	(-$2.14)	(-$2.87)	(-$2.33)
50 Percentile	(-$0.16)	(-$0.84)	(-$1.03)	(-$1.42)	$1.12)
75 Percentile	$0.54	$0.92	$0.61	$0.17	$0.64
90 Percentile	$2.91	$2.34	$2.31	$1.34	$2.08

Source: Lewin and Associates simulation based on 1985 cost reports of 970 SNFs.

Impact of the Recommended System on Access

The proposed system should have the effect of increasing Medi-Cal patients' access to more of the higher cost/low proportion Medi-Cal

facilities. While it is not in the state's interest to pay for care in the most expensive facilities, it appears appropriate to reduce the losses of "middle-range" facilities. These losses are attributable to higher spending on direct resident care.

As noted elsewhere in this report, the facilities that currently receive the highest profits on Medi-Cal residents are also those with the largest proportion of Medi-Cal residents. These facilities would experience the larger rate reductions (again, assuming no phase-in) under the proposed system, because the system by design takes some Medi-Cal money previously spent in facility profits and retargets it to resident care. In our view, it is unlikely that the somewhat lower profits in heavy Medi-Cal facilities would result in reduced access for Medi-Cal residents. These facilities (like all others) currently have a very strong incentive to select private payers over Medi-Cal residents; the proposed system per se would not alter the facilities' ability or willingness to substitute private payers for Medi-Cal residents.

On the matter of access, we should note that to our knowledge no empirical studies on the results of an actual shift from a flat rate system to a facility-specific cost-based system exist. Thus one cannot predict with complete certainty how facilities would actually behave with respect to accepting Medi-Cal residents when some facilities would have reduced profits and others reduced losses or even profit opportunities.

Impact on Quality
Compared to Labor Passthrough

This system achieves the basic objective of the Legislature's attempts to control expenditures through the labor passthrough mechanism but does so with greater effect, efficiency and accountability. Under the labor passthrough as currently conceived (i.e., in AB 1272 recenty passed by the Legislature but not signed by the Governor) every facility receives the

designated augmentation and must pass on a specified percentage to employees. As a consequence, the additional funds are not as targeted as they might be (e.g., facilities in the highest quartile of expenditures receive the same amount per Medi-Cal patient day - which is probably not a good bargain for the state). Additionally, the labor passthrough only deals with augmentation to an existing base rate whereas the recommended system focuses on the structure of the entire rate.

Should the state not adopt this change to a facility specific cost component rate system, we recommend that at a minimum, it place labor passthrough requirements in statute so that it can have some accountability on how its Medi-Cal dollars are being spent and can provide some targeting of funds for quality related expenses.

Examples of Proposed Rate-Setting Method

In order to clarify the method of rate-setting we propose and how it might impact on different facilities, we selected two facilities (the names have been changed) to illustrate the system, using data from our 1985 data base on 970 SNFs.

Example I: Reduced Profits with Protection for Increased Spending on Direct Care for a Low Spending Facility.

The Gateway Home is a 201-bed facility located outside of the Los Angeles geographic area. Its rate under the current system is $43.66, compared to costs of $39.69 per day, yielding a positive margin on Medi-Cal patients of $3.97 per day. Under the new system, profits in the base year would be reduced, but since the home is still below the limit on direct care costs, any increased expenditures in direct care that are made by the facility would be built into its rate when the system was rebased (so long as it was below the new limit).

Cost Component	Gateway Home Expenditures	Limits
Direct Care	$27.15	$29.47
Other	$12.54	$18.30

The new rate for Gateway Home is set as follows:

- Direct care portion = $27.15 (expenditures up to the limit)
- Other portion = $12.54 + .5 ($18.30 - $12.54) = $15.42
- Total rate = $42.57
- Profit under the new system = $2.88 per day

Example II: **Reduced Losses (Increased Rates) for a Facility with High Expenditures for Direct Care and Low Costs on the Other Component.**

The Skyview Home is 93-bed home in the Bay Area, where limits are somewhat higher than for the geographical area in which Gateway Home is located. The current rate for the Skyview Home is $47.38, only $3.72 higher than the rate for Gateway Home. But expenditures at Skyview Home are $56.41 per day of which 75 percent ($42.26) are for direct resident care, compared to 68 percent at Gateway.

Under the current system, Skyview looses $9.03/patient day on Medi-Cal residents. Under the new system, the losses are reduced by 70 percent to $2.64.

Cost Component	Skyview Home Expenditures	Limits
Direct Care	$42.26	$37.32
Other	$14.15	$18.75

The new rate for Skyview Home is set as follows:

- o Direct care portion = $37.32 (expenditures up to the limit)
- o Other portion = $14.15 + .5 ($18.75 - $14.15) = $16.45
- o Total rate = $37.32 + $16.45 = $53.77

Summary of Specific Recommendations

1. Adopt a prospective facility specific methodology as opposed to the current flat rate system.

2. Create two cost components:

   - Direct care items: nursing, dietary, and social service and training costs.

   - "Other" items: all other costs.

3. Each facility would be field audited to determine a base year's costs for each of the two components. These costs would then be projected forward to the midpoint of the rate year by the appropriate inflation factors.

4. Within each size and geographical category all the facilities' projected costs on each of the two components would be arrayed and an appropriate ceiling selected -- for example the median for the "other" costs and the 80th percentile for direct care costs.

5. Each facility's rate would be a combination of the two components.

   - The direct care component would be paid at the lesser of costs or the ceiling.

- The other component would be paid as follows:

  -- For those above the median, the median.

  -- For those above the median, the facilitiy's cost plus approximately half the difference between the facility's costs and the median.

6. All facility rates would be rebased every three years (i.e., a new rate established based on the facilities' actual audited costs and new limits established based on the array of the costs on each component for all facilities in each geographic and bed size class). In three situations an annual readjustment of selected facility rates would occur:

- Facilities with patient care related costs in the lowest quartile.

- Facilities who reduce their expenditures on direct care items more than 10 percent below their rate amount for that component. The state could pursue a policy of recoupment of the reduced amount in these situations.

- Facilities that request and are granted a readjustment because of special circumstances that have substantially altered their costs, e.g., a large addition to the facility.

7. Should the state not adopt this recommendation, it should at a minimum place labor passthrough requirements in statute. Under the existing system this is the best mechanism to target funds for quality enhancements by requiring that at least a portion of the cost of living increases and any additional augmentations are devoted to spending on direct patient care items.

B. RATE SETTING FOR HOSPITAL-BASED DISTINCT PART UNITS

Overall Recommendations

Currently, hospital-based units (82 as of 1986) are reimbursed at a rate equalling their reported costs, up to the median of the hospital-based array. For the rate year beginning August 1, 1987, the hospital-based limit is $152.44, or roughly three times the freestanding rate. The lowest rate is $60.26. While there is some justification for a higher rate for hospital-based units than for freestanding SNFs, there is little justification for a 300 percent differential. We therefore recommend that rates for hospital based units be altered to pay costs to the Medicare limit. An exception to this would be made for county owned facilities whose rates should continue to be determined as they are now.

Distinct Part Units Have More Nursing Hours and Higher Salaries

A portion of the difference between freestanding and hospital based units is due to higher nurse staffing with higher wages. A study of FY 81-82 differences in expenditures between hospital-based and freestanding units found that 30 percent of the difference could be accounted for by higher nursing wages and more nursing hours: 3.6 hours per patient day compared to 2.7 hours per patient day in hospital-based units compared to freestanding SNFs. It should be noted that the difference in nursing hours per patient day result from more licensed nurse time than nurse's aide hours whereas the difference in wage rates holds for all categories of nursing personnel, as shown below in Exhibit 34.

Exhibit 34

NURSING WAGE RATE, HOURS, AND SALARY AND WAGE EXPENSE PER PATIENT DAY
CALIFORNIA LONG TERM CARE FACILITIES BY TYPE
1985 and 1986*

Type of Facility	R.N. Hrs/Day	R.N. Rate	L.V.N. Hrs/Day	L.V.N. Rate	Aides & Orderlies Hrs/Day	Aides & Orderlies Rate	Total Hrs/Day	Total Rate
Hospital distinct part	.85	$13.53	1.11	$9.18	1.95	$7.08	3.91	$9.08
Freestanding facilities **	.23	$10.83	0.47	6.78	1.96	4.73	$2.66	$5.62

* Data on free standing facilities are for fiscal years ending in calendar 1985 whereas data for hospital based units is for fiscal years ending from July 1, 1985 to June 30, 1986. Differences in wage rates may thus be slightly overstated.

** Excludes facilities that have an associated board and care facility, since labor reports do not separate out staffing for these from the ICF/SNF.

Distinct Parts Have
Somewhat Sicker Patients

The greater availability of nursing staff and the higher ratio of licensed nurses to aides is to some degree justified by differences in patient acuity. We found that the average case-mix score in hospital-based units was 2.87, compared to 2.66 in freestanding SNFs (Exhibit 35). Using the Minnesota weighting system, this means that on average, residents of hospital-based units were modestly (less than 10 percent) more costly to care for with respect to nursing care than freestanding SNF residents.

Exhibit 35

DISTRIBUTION OF SNF RESIDENTS BY TYPE OF FACILITY (DISTINCT PART VS. FREESTANDING), CASE-MIX CLASS, AND PAYER

Case-Mix Weight	Class	Distinct Part[a]			Freestanding		
		Medicare	Medi-Cal	Total[b]	Medicare	Medi-Cal	Total[b]
(1.00)	A	3.4%	6.2%	5.6%	1.7%	7.2%	6.6%
(1.30)	B	0	4.8	3.6	2.5	8.7	7.6
(1.64)	C	4.1	1.1	1.5	0.4	0.6	0.6
(1.95)	D	17.7	12.5	13.0	13.0	12.6	12.6
(2.27)	E	6.8	10.5	11.3	9.7	13.6	13.4
(2.29)	F	13.6	3.6	5.2	7.6	2.4	2.4
(2.56)	G	6.1	7.5	8.0	4.6	10.3	10.3
(3.07)	H	5.4	11.4	10.2	7.1	13.1	14.1
(3.25)	I	4.8	15.1	12.6	8.0	16.6	16.3
(3.53)	J	0.0	1.0	1.0	0.4	1.3	1.1
(4.12)	K	38.1	26.5	28.1	45.0	13.7	15.0
Mean case-mix score		3.11	2.86	2.87	3.17	2.62	2.66
SD		1.00	.98	.97	.97	.91	.91
(N)		(147)	(562)	(879)	(238)	(4,030)	(6,460)

[a] Nearly half the Medi-Cal patients in one HB sample were from two very large county facilities. The average Medi-Cal case mix for these county facilities was 2.7; the average Medi-Cal SNF case mix for other HB units was 2.9.

[b] Includes cases with payer unknown and private pay.

Source: Lewin and Associates patient assessment study, 1987.

The actual case-mix differences between hospital-based residents and others may be somewhat greater than is indicated by the summary case-mix score, because the scoring system does not result in a higher case mix weight for residents who have more than one "special nursing treatment needs," as opposed to those who need only one. These "special nursing treatment needs" (e.g., tracheotomy care, decubitus care, other wound care) are costly for facilities to provide because they require the skilled service of licensed nurses. As can be seen in Exhibit 36, hospital-based units have more residents receiving each of the individual "special nursing treatments."

Exhibit 36

PERCENT OF MEDICAL SKILLED PATIENTS RECEIVING SPECIAL SKILLED NURSING TREATMENTS

	% of Medi-Cal Skilled Patients	
	Hospital Based	Free-Standing
Group I -- Special Skilled Nursing Treatments		
Decubitus (stage 1 or 2)	12.01	9.12
Decubitus ulcer (stage 3 or 4)	7.13	1.90
Other open, draining wound	1.87	0.99
(Requiring care TID or more)	(1.25)	(0.22)
Inhalation/O_2 therapy TID or more	4.36	0.12
Suctioning BID	.83	0.15
Suctioning TID+	4.57	0.12
(Tracheostomy BID)	(.21)	--
(Tracheostomy TID+)	(3.53)	(0.10)
Transfusions	0.18	0.07
Comatose	3.4	0.10
Ventilator dependent	0.88	0.02
IV therapy (excludes hydration)	0.18	0.02
Traction	0.35	0.25
Group II -- Special Skilled Nursing Treatments		
NG tube	9.73	4.22
Parenteral feeding (TPN)	--	0.02
Gastrostomy	5.13	2.48

Source: Lewin and Associates Resident Assessment Study, 1987

While the proportion of residents receiving any "special nursing treatments" is less than half for both hospital-based and freestanding SNFs, (47.1 percent and 19.8 percent, respectively), residents of hospital-based units are more likely to be receiving more than one "special nursing treatment" (Exhibit 37).

Exhibit 37

PROPORTION OF RESIDENTS IN HOSPITAL-BASED AND FREESTANDING NURSING HOMES RECEIVING "SPECIAL NURSING TREATMENTS," BY NUMBER OF TREATMENTS AND PAYER

Number of Special Nursing Treatments	Hospital-Based			Freestanding		
	Medicare	Medi-Cal	Total*	Medicare	Medi-Cal	Total*
None	30.6%	59.7%	54.2%	40.3	73.0	71.8
1	22.5	20.2	20.6	28.2	17.7	18.2
2	19.1	8.9	11.1	15.1	6.5	6.5
3	14.3	6.2	7.2	8.0	2.1	2.5
4	10.9	3.4	4.6	4.2	0.5	0.7
5	1.4	1.6	1.6	3.4	0.1	0.3
6+	1.4	0.2	0.7	0.8	0.1	0.1

* Includes Medicare, Medi-Cal, private, and those for whom payer information was missing.

Source: Lewin and Associates Resident Assessment Study, 1987.

In addition, data from the Resident Assessment Study provide evidence that residents in hospital-based units are (on average) more likely to be getting "restorative nursing" and "frequent physician visits" than residents

of freestanding facilities, as shown in Exhibit 38. These differences in "restorative nursing" are likely to reflect both differences in the acuity of residents in different settings (e.g., residents of hospital-based units are more likely to need "nursing instruction" because they have recent conditions) as well as differences in the availability of resources which in turn are likely to be a reflection of substantially different rate structures. Similarly, the rather dramatic difference between settings in the proportion of residents receiving physician visits more than once per week (15.6 percent in distinct parts and 0.8 percent in freestanding) is likely to reflect both differences in resident acuity, and the fact that it is often more convenient for physicians to visit nursing home residents in a hospital-based unit than in a freestanding facility.

Exhibit 38

PROPORTION OF RESIDENTS IN HOSPITAL-BASED UNITS AND FREESTANDING FACILITIES RECEIVING FREQUENT PHYSICIAN VISITS AND SELECTED RESTORATIVE NURSING PROCEDURES, BY PAYER

	Hospital-Based			Freestanding		
	Medicare	Medi-Cal	Total*	Medicare	Medi-Cal	Total*
Physician visits more than 1x/week	18.3%	14.1%	15.6%	2.5%	1.0%	0.8%
"Restorative Nursing"						
Patient teaching by licensed staff	29	28	26	6.3	5.3	6.2
Reality orientation	41	36	37	24.4	23.6	24.9
Range of motion	67	48	54	34.5	31.6	30.7
Ambulation	35	30	32	17.2	18.2	20.8

* Includes Medicare, Medi-Cal, private, and those for whom payer information was missing.

Source: Lewin and Associates Resident Assessment Study, 1987.

Despite these differences in case-mix and services rendered, the primary reason for the threefold difference in average costs of hospital-based and freestanding units is the substantially higher indirect costs of the hospital-based unit. Precise comparisons between hospital-based and free standing units are difficult because of differences in the cost reports, but the observed differences are dramatic:

- For example, the 1981-1982 CHFC study found that "indirect expenses" were twice as high in distinct-part units as in freestanding.

- As shown in Exhibit 39 below, while property costs comprised a slightly smaller percent of costs on average in hospital-based as in freestanding units the actual dollars were three times as high in hospital-attached units.

- Expenditures other than those in nursing salaries or property were more than five times higher in hospital-based SNFs compared to freestanding.

Exhibit 39

COMPARISON OF AVERAGE COSTS PER PATIENT DAY BY COST CATEGORY: FREESTANDING SNFS (1985)AND HOSPITAL DISTINCT PART SNFS (1986)

	Nursing Salaries	Property	Others	Total
Freestanding	$17.09 (35%)	$5.26 (11%)	$21.57 (55%)	$49.29 (100%)
Hospital Distinct Part	$35.15 (17%)	$15.72 (8%)	153.02 (75%)	$203.89 (100%)

Sources: Lewin and Associates analysis of cost reports and labor reports for freestanding SNFs with FYE 1985 and Hospital Distinct Part labor reports and Medicare Cost Report Summaries for hospitals with FYE July 1, 1985 to June 30, 1986.

The differences illustrated in Exhibit 39 above are so substantial that problems of data comparability become less crucial. It should be noted again however, that the cost reporting categories on the Medicaid cost reports for freestanding facilities and on the Medicare cost reports used by distinct parts are not precisely comparable. In the analysis above, we computed distinct part nursing salaries from the labor report on the Hospital's Disclosure Report submitted to the Office of Statewide Health Planning where it is likely that only directly-identified nursing staff are reported in the

SNF column. Hence, salaries for some supervisory nursing staff shared with the hospital may not be included.

Required Cost Allocation Procedures Overstate "Real" Costs of Distinct Parts

The differences described above are not a function of differences in case-mix, but rather a function of Medicare cost allocation procedures required of hospitals. Except for those costs directly identified (e.g., the salary of a nurse who only works in the distinct part) reported SNF costs are based on allocation formulae that in many instances tend to misstate the "true costs" of the hospital-based unit. For example:

- Property expenses (including interest and depreciation) are allocated on the basis of square feet between the acute care hospital and the distinct part. This means that the reported costs for the distinct part include a portion of the capital expenses associated with the radiology department and operating suites. Pieces of equipment that are directly used in a cost center (for example, an operating room table) are fully allocated to that cost center, but general property items such as the cost of construction of walls which are more expensive in a hospital operating room will be partly borne by the distinct part nursing unit.

- Administrative expenses are allocated on the basis of accumulated costs. The general administrative costs of providing acute care services are much more complex and expensive than those necessary for the provision of skilled nursing. While accumulated costs may be a more appropriate measure than square footage, again it is likely that allocated costs will result in a higher cost than those in a freestanding nursing facility.

- Costs of support services are allocated on the basis of gross patient revenues. In many cases, the skilled nursing facility in a hospital is assigned costs that wouldn't be relevant but for the fact that the facility is located within a hospital. Examples include costs associated with Medical Library, Medical Staff, Auxiliary Groups, Credit and Collection, Retail Operations, and Other Unassigned Costs. Although these costs are allocated based on the SNF's relatively small percentage of gross patient revenue, its comparable freestanding facility may have none of these costs.

- Costs of nursing administration are allocated on the basis of nursing FTE. A hospital tends to have a more complex administrative hierarchy than a freestanding nursing home. Even based on nursing FTE and allowing for how costs are assigned, it is probable that the SNF cost center will receive a higher cost than a freestanding unit.

In sum, the costs allocated to the distinct part are greater than the distinct part's share of costs. This has been recognized by Medicare in its rate-setting methodology for hospital-based SNFs. Medicare pays hospital-based SNFs (at present) costs to a ceiling, with a retrospective settle-up. The hospital-based upper limits, in brief, recognize only half the difference between 112 percent of the freestanding mean and 112 percent of the hospital-based mean costs, with an additional modest overhead adjustment for hospital-based SNFs.

The Medicare SNF methodology also adjusts the labor portion of the limits (for both hospital-based and freestanding facilities) by a wage index (derived from data on hospital wages) specific in California to each of 22 urban areas (all non-MSA California counties have the same wage index). For example, the Medicare limits for hospital-based SNFs in the Los Angeles/Long Beach MSA and in the Modesto MSA for facilities with cost reporting periods beginning on or after May 1, 1986, were $115.98 and $107.24, respectively (Exhibit 40).

Exhibit 40

MEDICARE UPPER LIMITS FOR HOSPITAL-BASED SNFs

MSAs	Published Medicare Limit For Facilities With Cost-Reporting Period 5/1/86-4/30/87	Approximate Update to January 1988 (Limit x 1.05)
Anaheim/Santa A.	$111.02	$116.57
Bakersfield/Kern	106.92	112.27
Chico	109.89	115.38
Fresno	102.73	107.87
Los Angeles/Long Beach	115.98	121.78
Modesto	107.24	112.60
Riverside/S.B.	110.29	115.80
San Diego	114.61	120.34
San Francisco	139.73	146.72
San Jose/Santa C.	127.13	133.49
Santa Barbara	105.17	110.43
Santa Cruz	109.66	115.14
Santa Rosa	114.67	120.40
Non-MSA	102.48	107.60

Source: Computed from methodology and data in Final Notice, F.R. 11253, April 1, 1986; and corrected at 51 F.R. 21807, June 16, 1986.

The Medicare upper limits for hospital-Based SNFs are considerably lower in most areas of California than the rate that Medi-Cal is paying. For example, projecting the Medicare upper limits for Los Angeles/Long Beach and Modesto forward to correspond to the current California Medi-Cal rate year, the Medicare limits are $121.78 and $112.60, while the Medi-Cal upper limit is $152.44. It appears unreasonable to us for Medi-Cal to pay more for hospital-based SNF services than Medicare, particularly in view of the evidence that Medicare SNF patients require and receive more nursing care in hospital-attached SNFs than do Medi-Cal patients (Exhibits 15 and 37).

County-Owned Hospital-Based SNFs

County-owned hospital-based SNFs differ substantially from other distinct part units in ways that indicate a different rate-setting methodology is appropriate. First, the cost allocation issue is less persuasive with respect to county distinct part units. Approximately 75 percent of the Medi-Cal patient days in county hospital-based units are from Laguna Honda Hospital, which has 1,082 SNF beds and 24 acute care set up beds, making allocation issues negligible.

Second, reported costs in county hospital-based units are more clearly attributable to Medi-Cal residents. In 1986, 87 percent of patient days in county hospital-based units were Medi-Cal (93 percent for Laguna Honda) compared to an overall average of around 62 percent in all hospital based units. As previously noted, Medicare and private payers in hospital-based units have higher case-mix (resource use) than Medi-Cal patients.

Third, although county hospital-based units have lower costs than others and would be less likely to be subject to the Medicare upper limit, any costs in excess of the limit might be borne 50/50 with the state as net uncompensated costs under the AB 8 county Health Services Program (so long as

the county is not already overmatched), regardless of where the limit were set. Thus, while some limits are clearly required to encourage a measure of efficiency, lowering the limit for county-owned distinct parts may shift some expenditures from the federal government to the state.

Finally, county hospital-based units are the providers of last resort and under their W&I Code 17,000 obligation perform a unique role in the state's system of providing health care for the poor. Our hospital discharge planner interviews reinforced the fact that county facilities are perceived to take patients that other facilities refuse to accept.

State-Owned Hospital-Based SNFs

Since state-owned hospital-based units share some of the same characteristics of county facilities, it might be argued that they should be treated the same for reimbursement purposes as the county hospital based units. We are not making a specific recommendation with regard to Medi-Cal rate-setting for state hospital-based units because HCFA has recently issued new regulations requiring that state owned facilities classified as SNFs, ICFs, or ICF/MRs must meet an independent Medicare upper limit test in the aggregate for each group. We believe that California will want to consider its Medi-Cal reimbursement system for state hospital-based SNFs in light of its overall policies for all state owned nursing facilities, a task that is beyond the scope of this project.

Specific Recommendations

1. Establish a separate payment methodology for county hospital-based units and other hospital-based units.

2. For county hospital-based units, rates should continue to be set as they are now (i.e., costs to the limit of the median).

3. For other hospital-based units, we propose that rates be the lesser of actual allowable costs or the Medicare upper limit for hospital based SNF's, for the hospital-based unit's particular geographic area, projected to the mid-part of the next rate year by the same inflation factors used for freestanding rates.

4. We make no recommendation regarding the state hospital distinct part units.

We estimate a savings of approximately $4 million (Total Funds) from instituting a Medicare allowable cost limit on non-county, non-state owned hospital-based units as shown in Exhibit 41. The rapid growth of distinct part units in private community hospitals in the last two years suggests that the magnitude of the savings will increase over time should the trend of expansion continue.

Exhibit 41

ROUGH ESTIMATE OF SAVINGS FROM CHANGING HOSPITAL DISTINCT PART RATES (1987-88)

Ownership	Projected Cost Under Current System ($000s)	Projected Cost Under New System	Change
State	$118,098	$89,068	$29,031*
Investor-owned	7,777	7,528	249
Non-profit	20,233	17,882	2,351
District	16,380	15,030	1,349
County	59,759	59,759	0

* We are not making a recommendation on how the state should reimburse the state hospital distinct part units.

Source: Department of Health Services rate study; Lewin and Associates estimates.

C. SPECIAL CARE RATES

Overall Recommendation

The state should pay special (higher) rates for the care of a small subset of patients with special care needs to provide better access for them to facilities and to ensure that they receive adequate quality of care (by helping to ensure that facilities that care for such residents have sufficient resources). This recommendation can potentially be implemented without major administrative disruption by utilizing the system in place for the current limited subacute category of patients.

There is a Subset of Heavy Care Medi-Cal Patients That Do Not Qualify for the Subacute Rate but Who Have Serious Access Problems

We considered the possibility of proposing that California adopt a full case-mix system, similar to that found in states like New York, Minnesota, and Maryland. For reasons discussed in Chapter IV, we concluded that California's need for such a system at this time did not outweigh the disadvantages of undertaking so major a change. Nevertheless, the available evidence indicates a clear need, in our view, for additional Medi-Cal expenditures specifically targeted on Medi-Cal patients with very special needs.

The current subacute care rate provides for a very small number of patients with the most severe needs. In order to qualify for the special rate, a patient must need at least three very costly skilled nursing services (e.g., ventilator-dependent, comatose, and tracheostomy with suctioning). The population who will ultimately qualify for such rates is thought to be no more than 300 - 500. At present, the total number of subacute beds for which the state has contracts for Medi-Cal patients is approximately 100.

Some argue that the subacute care rates are too low. While the rates paid for these subacute patients are two to three times the regular Medi-Cal rates, some facilities contend that the very high staffing standards required may result in continued facility losses on these patients at the Medi-Cal rate. It appears to us that a facility would have to have a sufficient volume of subacute patients in order to afford the staffing required at the current rates, given that staff need to be hired in increments of whole persons, which invariably leads to "excess" nursing hours when one tries to meet minimum standards for just a few patients.

Regardless of the appropriateness of the rate for the current subacute class, it is clear that a program designed for 300 - 500 patients will do little to relieve the serious access problems reported to us by hospital discharge planners. The hospital discharge planners whom we interviewed nearly universally described having substantial placement problems for "heavy care" Medi-Cal patients of all types, though those requiring special skilled nursing services (tracheostomies, decubitus care, tube feeders) were said to be especially hard to place.* As one discharge planner noted, "Any Medi-Cal heavy care [are hard to place] but the more tubes they have, the more difficult it is."

Adverse Consequences for Medi-Cal Patients with Special Care Needs

There are three potential adverse consequences for hard-to-place Medi-Cal patients with special care needs:

- Some back up in the hospital, where Medi-Cal pays for administratively necessary days at a rate (currently $152) which is higher than the freestanding subacute rate for non-ventilator-dependent patients.

- Some will eventually be placed in a SNF, but options will be very few.

- Some patients may go home (with home care) very sick.

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* Appendix B reports the responses of discharge planners at 29 hospitals to 2 questions: 1) "We are interested in whether you have problems placing patients in nursing homes. Could you please describe the current situation at your hospital?" and 2) "Which patients are the hardest to place and why?"

The notion that some patients are going home very sick for lack of nursing home placement is particularly troublesome. Only two (of 29) hospital discharge planners volunteered this, but we did not ask a specific question that might have better determined the frequency of this occurrence. As one discharge planner told our interviewer, "Patients are going home with home health care sicker than those going to nursing homes." The discharge planner thought there must be a law that prevents a SNF from taking patients with IVs. Another discharge planner said, "The SNFs can't take them so we send patients home on IVs." She said she has sent patients who can't take care of themselves home with huge wounds almost to the bone and with colostomies. While such situations might be rare, we were also told by one of Medicare's fiscal intermediaries, Blue Cross, that "a noticeable number" though "probably less than 1 percent" of the home care cases that they review are at an extraordinarily high skilled level including patients with chest tubes and at least one memorable patient sent home with a dopamine drip.

Estimates of the Number and Type of Patients Needing Special Care

In our view, a "Special Care Class" rate add on should be developed for a subset of the class of "heavy care" Medi-Cal patients: those who require treatments involving skilled nursing services. These patients are comparatively the most costly to care for and they are at risk of not being provided appropriate skilled nursing services (either because they are sent home or because they go to facilities that lack appropriate resources). This problem presents the clearest threat to quality of care for Medi-Cal patients that was revealed during our study.

A "Special Care Class" can be identified that clearly differentiates this subset of patients from general heavy care residents. Over 40 percent of the Medi-Cal SNF patients in our sample were dependent in 7-8 Activities of Daily Living, indicating that California's Medi-Cal SNF population is, in

general, substantially heavier care than for example, is Minnesota's total nursing home population. But the size of the population needing special nursing treatments is limited, making feasible the concept of a Special Care Class rate, administered in a fashion somewhat like the current subacute rate. Exhibit 36 shows the proportion of Medi-Cal patients (from our Resident Assessment Study) requiring different special nursing treatments; an estimate of the potential number of such patients is shown in Exhibit 42. Based on these data, we estimate that a Special Care Class rate could be applicable to less than 8 percent of the entire Medi-Cal SNF population if tube feeders were excluded, and would encompass 10 to 12 percent if those who are tube fed were included.

Exhibit 42

ESTIMATED NUMBER OF MEDI-CAL SKILLED PATIENTS (ONE-DAY CENSUS) RECEIVING SELECTED SPECIAL SKILLED NURSING TREATMENTS: BASED ON 1987 RESIDENT ASSESSMENT STUDY

	Estimated Number of Medi-Cal Patients	
	Hospital Based	Free-Standing
Group I -- Special Skilled Nursing Treatments		
Decubitus ulcer (stage 3 or 4)	167	917
Other open, draining wound	43	652
Inhalation/O_2 therapy TID or more	102	667
Suctioning TID or more	102	181
Transfusions	4	25
Comatose	80	456
Ventilator dependent	21	25
IV therapy (excludes hydration)	4	25
Traction	8	123
Group II --		
Nasal/gastric (NG) tube	227	2,010
Parenteral feeding (TPN)		
Gastrostomy	120	1,079

Note: Assumes 2,341 hospital-based Medi-Cal patients (1985 census) and 49,034 freestanding Medi-Cal skilled patients (12/10/86 census). Estimates are derived by multiplying percentages from the 1987 Resident Assessment Study (Exhibit 32) by these census figures. The smaller the number, the less reliable is the estimate.

Source: Lewin and Associates Resident Assessment Study1987; OSHPD Annual Reports of Hospitals and SNFs/ICFs, 1986.

Some clinicians and policy makers worry that paying extra for tube feeders might perversely encourage providers to use NG tubes excessively rather than expending the effort to help wean patients. There are, however, good reasons for including persons who are tube fed in the class eligible for a special rate:

- There is, at present, no empirical evidence to our knowledge that paying a higher rate for persons who are tube fed leads to excessive tube-feeding rates, although there are anecdotes to that effect.

- Persons requiring tube feeding were consistently mentioned as among those who are the most difficult to place.

- Research elsewhere clearly indicates that tube fed patients are more time-consuming to care for than others (as much because of the other care needs of persons who are so sick and debilitated that they can not eat as because of the actual tube feeding itself, which can take less time than spoon feeding).

- For persons who do not qualify for Medicare, the cost of the tube fed nutrients is substantial (and must be included in the Medi-Cal rate).

A number of options (other than excluding tube feeders altogether) might be tried to alleviate concerns regarding potentially inappropriate incentives involved in paying a special higher rate for persons who are tube fed. First, special monitoring of tube feeders could be established; perhaps including more frequent reauthorizations and evidence of concerted effort to wean those who could potentially be returned to regular feeding. Potentially, the tube-feeding rate could be increased if patients were retrained to regular

feeding. Although the numbers in the sample were extremely small, one of the very few types of patients for whom "outcome incentive payments" appeared to work in the San Diego experiment were tube feeders.

Alternatively, the "Special Care Class" could include only gastrostomy patients (about half the tube feeders). A surgical procedure is considerably less likely to result from a financial incentive. In addition, Medi-Cal could pay separately for the tube-feeding supplements, at cost. Or if there are concerns that nursing homes would have an incentive to "create a need" for nasal-gastric tubes Medi-Cal could pay the higher rate only for patients admitted with an nasal-gastric tube or gastrostomy.

We are recommending that the Special Care rate be designed for patients with identified needs for skilled nursing <u>treatments</u>, even though we are aware that some patients (e.g., those with severe dementias) can be more costly and demanding to care for than those who need identified treatments like tube feeding. We recommend this approach because the need for and provision of decubitus care, tracheostomy care, tube feeding, and so forth can be determined reasonably objectively. On the other hand, specifying degrees of mental impairment and objectively identifying persons with costly behavioral needs is relatively more difficult. We would, however, recommend that if California does decide to develop a Special Care rate that an Advisory Group consider the possibility of including persons with costly behavioral needs.

Hospital Distinct Part SNFs Have a Relatively High Percentage of Special Care Class Patients, But the Majority <u>of These Patients are in Free Standing Facilities</u>

It is arguable that the availability of hospital-based units, with their considerably higher rates (even under the modification that we propose) and higher staffing already provide a different level of care for these

"Special Care Class" patients. There is some truth to this argument. However, although the hospital-based distinct part units are already treating a somewhat more acute set of patients, relying on them alone to serve these heavy skilled patients will not be sufficient.

First, it should be noted that while hospital-based units are more likely to care for patients with special nursing needs, a larger proportion of the total Medi-Cal special care population is being cared for in freestanding facilities. For example, 7 percent of hospital-based Medi-Cal patients in the sample had severe decubiti (stage 3 or 4), compared to 2 percent in freestanding facilities (Exhibit 36), but because there are so many more Medi-Cal patients in freestanding SNF's our data indicate that about 85 percent of the Medi-Cal patients with severe decubiti are in freestanding facilities (Exhibit 42). The provision of a "Special Care Class" rate available to freestanding facilities would better assure that facilities that take such patients have the resources to care for them properly.

Second, our survey of hospital discharge planners indicated that hospital-based units (except those that are county owned) were as reluctant to take Special Care patients from other hospitals as freestanding facilities - suggesting that unless a Medi-Cal patient happens to be hospitalized in a facility that has a distinct part SNF unit, the Medi-Cal patient with Special Care needs will have serious access problems.

Example of Rate Setting Methodology
for Special Care Class Patients

In our view, rates for special care residents should be facility-specific rates, computed as a multiple of a facility's "direct care" rate component under the proposed system. For example, "Skyview Home," as described earlier, is spending $42.26 per day on "direct care" (nursing, dietary, social work, training -- of which the largest component is nursing).

However, because Skyview Home is over the limits ($37.32, in the simulation based on 1985 cost reports), the home receives $37.32 for "direct care," and $16.45 for "other." If the Special Care rate were an "add-on" at, for example, 25 percent of the "direct care" rate, Skyview would have a Special Care rate of $63.10:

"Direct care" rate component	=	$37.32
Add-on for special care	=	9.33
"Other" rate component	=	16.45
Special care rate		$63.10

There are two approaches the state might consider for determining the level of the special care add-on. First, a "resource use" or time study could be conducted in a sample of California homes to determine how much more nursing staff time is spent on residents with special nursing treatment needs compared to others. In effect, this approach means doing in California (at least on a small scale) the type of study that was done in Colorado, Texas, Minnesota, and New York when the states developed their case-mix classification and weighting systems.

Alternatively, California could convene an "expert opinion" panel to estimate an appropriate add-on for special care. This panel could make judgments after reviewing the results of time and resource use studies from other states and taking into consideration the type of staffing they thought appropriate.

Estimates of Total Cost of a Special Case Class Rate

The total costs for Medi-Cal of implementing a Special Care rate are a function of the amount of the add-on and the number of patient days for which Medi-Cal paid the Special Care rate. Exhibit 43 shows estimates of Medi-Cal expenditures under various assumptions.* As can be seen, the additional costs would be relatively modest: for example, if 10 percent of patient days were paid at a Special Care rate that included a 25 percent direct care add-on, there would be about a 2 percent increase in total Medi-Cal nursing home expenditures.

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* We estimated the amount of the add-on by multiplying average per diem expenditures on direct care for the FY 1985 cost reports in our data set by various percentages. To estimate costs and rates for 1988, for example, the cost/rates should be multiplied by about 10 percent to account for inflation.

Exhibit 43

ESTIMATE OF ADDITIONAL MEDI-CAL COSTS OF PAYING VARIOUS "ADD-ON" RATES FOR SPECIAL CARE RESIDENTS

Percent of Total Medi-Cal Patient Days Paid at Special Care Rate	Additional Cost to Medicare	Percentage Increase Over "Direct Care" Component of Rate Paid as "Add-On" 20%	25%	30%	35%
3%	Average "add-on" daily rate	$5.96	$7.45	$8.93	$10.42
	Medi-Cal costs $ (millions)	4.6	5.7	6.9	8.1
	% increase*	.5	.6	.7	.8
5%	Average "add-on" daily rate	$5.96	$7.45	$8.93	$10.42
	$ (millions)	8.0	9.2	11.5	13.4
	% increase*	.7	.9	1.2	1.4
10%	Average "add-on" daily rate	$5.96	$7.45	$8.93	$10.42
	$ (millions)	15.4	19.2	23.1	26.9
	% increase*	1.5	1.9	2.3	2.7

* The estimated percentage increase over FY 85-86 Medi-Cal nursing home expenditures represented by cost of special care rate payments.

In order for the state to ensure that the extra dollars were being spent as designed (to increase access and help ensure quality of care for special care residents), the state could retrospectively recoup any "profits" (the difference between allowable expenditures and Medi-Cal dollars paid) made on direct care for facilities that took Special Care residents. We do not recommend that all facilities be required to demonstrate that they increased spending on direct care by the exact amount paid as a special care add-on because the state is interested in promoting access by reducing facilities' losses on hard-to-place residents.

Administration of the Special Care Class Rate Can Follow the Sub-Acute Model but with Greater Flexibility

The Special Care program could be administered along the same lines as the current subacute rate system including:

- Contracts between the state and providers specifying special rates and patient care requirements.

- Close monitoring of the Special Care Class patients by Medi-Cal field office nurses, who could also serve as the persons responsible for determining whether a patient qualified for the special rate.

We further suggest that the Special Care system not require separate units for Special Care patients and that a facility's total staffing pattern and number of Special Care Class residents be taken into account in contract specifications in a manner that does not preclude facilities from taking only a few Special Care patients. For example, if it was decided that Special Care residents required 5.0 nursing hours per day and the statewide average nursing hours per day were 3.0, then the staffing requirements for a facility that took Special Care residents might be computed as follows:

- Number of "regular" patients = 95
- Number of special care patients = 5
- 95 x 3.0 = 285
- 5 x 5.0 = 25
- Nursing hours required = (285 + 25) ÷ 100 = 3.1 hours per day

Specific Recommendations

1. Identify a group of special care residents (Special Care Class); the group should include those nursing home residents who need identified, special skilled nursing procedures.

2. Provide an add-on rate for patients that qualify for the "Special Care Class." The amount of the add on component to the rate can be determined through a resource use study on California patients or through consensus of expert opinion.

3. Develop an administrative mechanism for implementing the Special Care Class rate that relies on contracting and frequent site visits like the subacute system, but that allows greater flexibility particularly in regard to the need for separate staffing.

D. REPORTING AND AUDITING

General Recommendation

The lack of accountability on how funds are expended is one of the serious problems with the current rate-setting system. There is no consequence for a facility's nonconformance with OSHPD accounting and reporting regulations nor for audit exceptions found in routine annual rate field audits by the Department of Health Services. If the state accepts the recommendation to adopt a facility-specific cost centered reimbursement system accurate cost reports for each facility will be a necessity. More focus on these administrative components of the rate-setting process will be required to achieve this end. The focus of the discussion in this section is on the changes that will be required if the state adopts Recommendation A, although many of them would be beneficial even if the current flat rate system is maintained.

Accounting and Reporting Regulations Should Be More Stringently Enforced

Under a facility-specific cost component-based system, cost reports submitted by facilities must be consistent in their classification of expenditures into cost centers. As indicated in Chapter III, the Office of Statewide Health Planning and Development (OSHPD) desk reviews currently identify a substantial number of misclassifications, and the small sample of field audits on accounting compliance have yielded some problems in the consistency with which the required Chart of Accounts is being used.

OSHPD has the authority under current regulations to impose penalties for noncompliance with its accounting and reporting standards, but to date no such sanctions have been applied. Consistent errors in accounting and reporting should result in penalties so that the state can be assured of consistency and accuracy in the reports that it receives.

Audit Activity Will Increase Under a Facility Specific Rate-System

In order to develop the base year's costs for each facility, it will be necessary to field audit each facility's cost report. Under the current flat rate system a general audit adjustment based on a sampling of facilities is applied to the median of each class in determining the rate. In a facility-specific rate system it is inequitable to adjust each facility's rate by a general industry audit adjustment factor.

During the three-year period between the rebasing of the entire rate structure, field audits will only be required if a particular facility's rate is to be adjusted. There are three categories of facilities who might qualify for a change in rate during year two or three:

- Facilities in the lowest quartile of expenditures on the direct care cost component in year one will have a rate adjustment in the subsequent year if their first-year cost report indicates they spent more on this cost component than projected in their rate.

- Facilities whose cost reports indicate a decrease of more than 10 percent in the direct care component from their projected rate will have a rate adjustment in the subsequent year to eliminate any profit made at the expense of direct patient care.

- All other facilities will be able to apply for a rate adjustment if events occur which warrant a re-examination of the facility's rates, e.g., a significant expansion of facility capacity.

In each of these cases a full field audit will need to be conducted before the facility rate is adjusted.

In the third year of the existing rate, all of the facilities will again be field audited in order to develop a new base from which to determine ceilings and each facility's new three-year prospective rate. It is likely that during the first round of field audits on all the facilities there will be more exit conference requests and more appeals than under the current system, since the results of the audits will have a direct impact on each facility's rate.

The Department of Health Services Audits and Investigations Unit provided us rough estimates of potential increases in personnel costs to complete field audits of all nursing homes within a one-year time frame. If audit hour time were increased from the current budgeted 120 hours for routine rate audits to 350 hours in order to accomplish a more complete audit, the cost of estimated staff increases would be approximately $17 million. Their

estimate of 350 hours would make these audits equivalent in hours to what is budgeted for general acute care hospitals. This estimate is in our opinion too high since the scope of activities and required audit program is more complex in a hospital than a nursing home. If the number of hours required were only twice rather than triple the current amount, this cost estimate would be cut in half. If some reassignment of audit staff were made to accommodate the higher one-year level of activity, the costs could be correspondingly reduced further.

Title 22 of the California Administrative Code provides for three levels of appeal on audit exceptions. At the first level the provider has 60 days to file an appeal which can be a simple statement of disagreement with the auditor's findings. The auditor writes an opinion paper on each issue in question but at this first level these are not extensive documents. A hearing auditor in the Office of Administrative Appeals conducts an informal hearing and issues a ruling. No attorneys are involved in the process.

Appeals of the decision of the hearing auditor go to an administrative law judge within the Department of Health Services' Office of Legal Services. At this level attorneys for the Department and the provider submit briefs. If attempts to settle the case fail, a formal hearing will be held, and a proposed decision written by the administrative law judge. The proposed decision is submitted to the Director of The Department for approval. The provider's recourse from an adverse decision by the Director is to file suit in Superior Court.

The Investigations and Audits Unit estimated an increase of around $750,000 to deal with additional workload in preparing materials for appeal if the rate of appeal were to increase to a level comparable to what occurs with acute care hospitals. The Office of Administrative Appeals estimated a potential workload increase of $115,000 if there were to be a sixfold increase in activity at the first level of appeal. This estimate in our opinion may be

too low since so few facilities currently appeal. We do not have information on potential cost increases for second level appeals.

Intervening Year Accountability Can Be Improved

Under the proposed system there would be no field audits during the intervening years between the rebasing of the rate system, except for the three categories of facilities where individual facility rate adjustments might be made.

The state should endeavor to improve the quality of data reporting during these intervening years even though the cost reports will not actually be used for setting a particular facility's rate. Tracking changes in expenditures during the intervening years will be important for anticipating budget impacts in the subsequent rebasing and for assessing how well the incentives are achieving their objectives.

We therefore recommend that the desk review function currently under the auspices of the Office of Statewide Health Planning & Development (OSHPD) be expanded to include a review of nonallowable Medi-Cal cost reporting (not at present one of the responsibilities of OSHPD). While distinguishing allowable from nonallowable costs can not be thoroughly achieved through a desk review of cost reports, selected areas of consistent errors could be monitored more closely. Specific guidelines should be developed for facilities to use in reporting items so that at least some of the nonallowable cost elements could be identified on the cost data available for analysis in the intervening years.

Specific Recommendation

1. The state should enforce more vigorously the accounting and reporting standards of nursing home cost reports.

2. All cost reports should have a full field audit in a base year in order to establish cost component ceilings and specific facility rates.

3. In the intervening years between the rebasing of the rate system only those facilities in selected categories will require field audits in order to readjust their individual rates.

4. More rigorous desk reviews of cost reports in the intervening years between full rebasing could result in greater reliability in the reporting of Medi-Cal allowable costs.

E. ALTERATIONS IN INFLATION FACTOR AND CLASS GROUPINGS

Overall Recommendation

The state should decide upon an appropriate means for setting inflation factors that will be consistent from year to year and should revise its size/geography groupings for ICF facilities. Both of theses actions can be taken independently of following the other recommendations.

Inflation Factor for Updating Components of the Rate

The use of an "inflation index" is necessary in California's rate-setting methodology in order to account for facilities with different fiscal periods and to set prospective rates that take into account expected

increases in the cost of things such as labor and supplies that nursing homes must purchase. California currently uses three separate inflation adjustments for labor, property taxes (assumed to increase uniformly at 2 percent per year), and "all other" costs (except capital which is treated as a fixed cost).

Labor costs are updated in a two-step process. The Department uses increases in actual nursing home wage expenses (as reported to the state Employment Development Department (EDD) for unemployment insurance purposes) through the latest time such information is available. From that point to the midpoint of the budget year the state has used a variety of factors, in recent years the budgeted percent salary increases for state employees. In the FY 1987-88 reimbursement study, the state, after a review of the issue, used the Data Resources Institute (DRI) projections for nursing home labor. The DRI nursing home labor index is based on national data on salaries and wages for nursing home personnel collected by the Bureau of Labor Statistics (BLS) and projected forward using an econometric model developed by DRI. There are a number of problems with the state's current method for trending forward labor costs:

- The lack of consistency in the source for updating the labor factor opens the rate setting process to negotiation each year since different indices show different figures.

- The Employment Development Department (EDD) data are problematic because they do not provide information of expenditure changes using a consistent unit of analysis. The EDD collects information on total wages paid, total persons paid wages, and total "reporting units". Using "total persons paid wages" in the denominator makes the index sensitive to changes over time and across counties in the relative proportion of part time and full time workers. The Department has chosen to use "reporting units"

in the denominator, but a "reporting unit" can be several facilities belonging to the same orgainzation, one single facility, or a portion of a larger organization.

The Data Resources Institute (DRI) index for projecting nursing home labor costs is, in our view, a more appropriate factor than others historically used by the Department since it has data specifically on nursing home personnel. Its failing is that the data are available publicly only on a national basis. Most experts agree that it is better to have national data based on an appropriate labor category than local data based on an inappropriate labor category.

"Other Costs" (e.g., supplies, energy, food, drugs, telephone) are updated with the California Consumers Price Index (CCPI) for "All Urban Consumers", with projections by the Department of Finance. This index has the advantage of using California data. The distinct disadvantage is that a "market basket" of items normally bought by general consumers will be considerably different from a "market basket" of items bought by a nursing home.

Because of the importance of the inflation adjustment factor, we suggest that California consider contracting with an independent firm with expertise in inflation projections (DRI is one of several) to develop an index for California. The index should reflect the actual distribution of different types of expenditures in California nursing homes (e.g., utility costs versus medical supplies) and incorporate indices that are reasonable proxies based on California or regional data where possible, for changes in those costs.

The Method of Adjusting for Geography and Bed Size for ICF Facilities Should Be Revised

As indicated in Chapter III, the small number of facilities in some of the six ICF size/geography categories create inconsistency and lack of predictability in rates from year to year. Exhibit 44 shows the relationship of rates among the six categories over the last five years.

Exhibit 44

RELATIONSHIP OF ICF RATES AMONG CATEGORIES ACROSS YEARS*

	Los Angeles		Bay Area		All Other	
	1-59	60+	1-59	60+	1-59	60+
1987	1.04	1.02	1.15	1.09	1.07	1.00
1986	1.15	1.00	1.12	1.11	1.02	1.08
1985	1.28	1.00	1.23	1.00	1.03	1.02
1984	1.27	1.15	1.22	1.11	1.16	1.00
1983	1.33	1.10	1.21	1.10	1.10	1.00

Source: Department of Health Services Rate Studies

The consistent patterns have been the higher rates in the Bay Area (where wage rates are higher) and in the small facilities in Los Angeles. The existence of these relatively consistent differences suggest that some size and geography categories should continue to be used.

The easiest and most reliable alternative to the present method of determining a median for each category would be to use the adjustments derived from the SNF size and geography groups. The variations among SNF categories are based on a far larger number of facilities and the same input prices and factors of scale that cause the SNF differences should be relevant to ICF.

To establish the ICF rate, all ICF facilities would be arrayed in a single class and the median facility cost would be the base ICF rate or under the recommended system the basic ceilings for the direct care and other cost components would be determined from the full class of ICFs. This rate (or ceiling) would then be adjusted for each of the ICF bed size and geographical classes by the ratio of SNF costs for that category to average SNF costs for all facilities. For example,

$$\text{Rate for Bay Area 1 - 59 bed ICF} = \text{ICF Base Rate (Median of all ICFs)} \times \frac{\text{Bay Area Average SNF Cost}}{\text{Average of All SNF Costs}}$$

The above would be appropriate if the current flat rate system were continued. If our recommended facility specific cost component system were adopted, the above general methodology would be used in setting the ceilings for the two cost components.

Specific Recommendations

1. The state should develop and use a consistent methodology for inflating its labor and other costs.

2. The Data Resources Incorporated (DRI) index for labor costs is a more appropriate method for projecting nursing home labor costs than the state employee wage changes. The DRI figures should be used to cover the entire period from the cost report date to the budget year thus eliminating the use of the Employment Development Department data for a portion of the update.

3. The state should consider contracting with an outside econometric firm to develop an inflation update model that would better reflect the distribution of nursing home expenditures other than labor than does the California Consumer Price Index.

4. The state should change the method for allowing for ICF size/geography differences by combining all ICFs into one category to develop a base rate (or ceiling in a facility-specific cost component method) and then adjusting this for each size/geography class based on SNF experience.

F. IMPLEMENTATION

General Recommendation

The careful implementation of the recommendations in this chapter will be critical to their success. They represent a substantial change but are economically, politically, and administratively feasible. Administration of the system will be somewhat more costly, but is well within the state's technical capacity to implement.

There Should Be Active Oversight and Participation in Implementation

There is a natural tendency for bureaucracies to move reluctantly and slowly toward change, particularly where administrative costs associated with the conversion might increase. Legislative oversight can provide an appropriate balance since it allows for all parties with an interest in the issues to have a forum through which they can be apprised of implementation progress and express their concerns.

Efficient implementation will require the active participation of both industry and consumer representatives. The Administration should convene advisory groups, as appropriate, to assist in the details of the implementation of particular components of the new system.

Potential Increases in Administration Costs for the State and for Facilities

The administration of the current rate setting system is accomplished by a small staff that has been sufficient to maintain the flat rate system. The ongoing administration of the recommended system will not be more difficult than the current approach, but the initial development and transition will require additional staff resources and should be phased in gradually. There are also likely to be some cost impact on facilities. As noted throughout this report, nursing homes have not been held accountable in the past for accurate accounting and reporting of their costs. Complying more completely with these regulations will entail additional effort and/or resources for some facilities.

Transition to the New System

The nursing home industry has accommodated over the last decade to the flat rate system. The relative stability in the industry is an advantage to patients, facilities and the state. Any change in the payment system could cause disruption particularly for those facilities who might fare less well financially under the new system. The use of transition rules that cushion the financial change for any facility should be considered. For example, under the modeled scenario presented in Recommendation A, facilities with the greatest proportion of Medi-Cal patients (over 75 percent of their patient days are Medi-Cal) would have an average reduction in their rate of $1.42 per day on Medi-Cal patients under the first year of the new system and the 10 percent of the facilities in this group that would experience the largest decline in rates would lose at least $4.11 per patient day. The state might consider limiting the reduction in rates to these facilities. By lessening the efficiency incentive and/or lowering the ceiling on the direct care cost component, the state can save dollars which could be used to ease the transition for facilities that would have the greatest reduction in rates under the new system, while still maintaining the budget neutrality of the new system.

Specific Recommendations

1. The Legislature should play an active role in oversight of the implementation of the recommendations, and industry and consumer representatives should be involved in an advisory role as much as possible.

2. Transition rules should be considered to mitigate some of the impact on facilities that will experience significant rate reductions in the shift from the current to the new system. The ceilings and efficiency incentives can be adjusted to produce whatever level of savings is determined appropriate to target for easing the impact of the transition on those facilities most adversely affected.

G. LONGER-TERM MONITORING AND DEVELOPMENT ACTIVITIES

General Recommendation

The state should continue to monitor and evaluate the reimbursement system so that alterations can be implemented efficiently if and when additional problems arise. In particular the state should continue to monitor the supply of beds and Medi-Cal patients' access to them and should do the developmental work necessary to implement a reimbursement methodology for the capital-related component of the rate system.

Capital Costs

The state has two important objectives as it considers the reimbursement of property: providing sufficient incentive to keep enough facilities in the market to meet the access needs of the patients it funds and creating an incentive for facilities to maintain their physical plant at an

acceptable level. Under California's current flat rate system there are no allowances for the differences in capital-related costs experienced by facilities. Facilities with older physical plants and low financing costs benefit while newer facilities with higher capital-related expenditures are at a disadvantage.

As can be seen in Exhibit 45, facilities that profit most on Medi-Cal patients spend less on property both in actual dollars and as a proportion of total costs. The data available, however, do not allow us to determine to what extent the nursing homes that spend more on property do so because of newer facilities or because of other reasons, such as a more recent acquisition. Nevertheless, it is clear that California's current approach to property reimbursement is not finely tuned to promote state goals other than cost containment and does contain disincentives for capital improvements which can, in fact, have an impact on residents' quality of life.

Exhibit 45

RELATIONSHIP OF PROFITABILITY ON MEDI-CAL PATIENTS TO EXPENDITURES ON SELECTED NON-PATIENT-RELATED ITEMS (1985)

	Expenditures Per Patient Day					
	Property		Administration		Plant Operations	
	$	%	$	%	$	%
Medi-Cal rate more than 10% higher than average total cost (N= 170)	3.34	8.6	5.20	13.4	2.71	7.0
Medi-Cal rate between 0 and 10% higher than average total cost (N=304)	4.47	10.5	6.25	14.6	2.94	6.9
Average total cost between 0 and 10% higher than Medi-Cal rate (N=342)	5.25	11.3	7.02	15.1	3.18	6.9
Average total cost between 25 and 50% higher than Medi-Cal rate (N=80)	7.32	12.0	8.65	14.2	4.26	7.0
Average total cost more than 50% higher than Medi-Cal rate (N=68)	8.92	9.8	13.22	14.9	5.72	6.6

Source: Lewin and Associates cost analysis.

While we are aware of the problems with the current system, we do not recommend the state's adopting a special methodology for capital-related expenditures at this time for the following reasons:

- These costs represent a relatively smaller portion of the overall nursing home expenditures (9 to 10 percent) and do not have so immediate an impact on patient care. The needs to obtain better accountability, target funds for direct patient care items, and provide better access to care for heavy care patients, appear more serious at this point.

- There has been a more rapid increase in the supply of beds in the last two years, and we found considerable enthusiasm for new construction on the part of many people we interviewed who are planning to proceed with the development of new facilities.

- There is major uncertainty however about how much addition to the bed supply there will be in the next three to five years. It is prudent for the state to refrain from altering too drastically the capital component of the rate until the impact of changes in CON, tax law, and the other recommended changes in the rate system have a chance to work themselves through.

- Capital-related reimbursement systems are exceedingly difficult to understand, i.e., their incentives are not particularly transparent. For example, the percentage used in determining the rate in a fair rental system is subject to multiple interpretations each of which leads to a quite different expectation of what the percentage should be. To fully evaluate capital options will require collecting new information (e.g., appraisal data in at least a sample of nursing homes) and considerable discussion so that all parties become informed of the consequences of different choices.

- The recommendations we have made will require considerable attention to implement efficiently and without undue disruption.

Attempting to modify capital-related costs at the same time in our opinion could interfere with the other more critical recommendations.

If the state adopts the recommendation for facility-specific cost centered reimbursement it will probably want at some future date to separate capital costs out from the non-direct care ("other") component and treat capital costs separately. The state should therefore begin to consider options. We recommend analysis of at least the following four reimbursement method options:

1. Simple Class Rates

The simplest approach would be to break out capital costs (interest, depreciation, leases, and rentals) and pay at the median. In our view, this would be a poor choice because it does not address the problem of disincentives to upgrade; in fact, it makes it worse because facilities would lose the ability to "trade off" expenditures within the larger non-patient care related cost component.

2. Modified Conventional Capital Approach

Another simple and somewhat better approach would be to establish a "ceiling" and a "floor" for capital expenditures. Facilities above the ceiling (e.g., the 75 percentile of capital costs) would get the ceiling rate; facilities below the floor (e.g., the 25th percentile) would get to keep half (or some portion) of the difference between their costs and the floor; facilities between the floor and the ceiling would get their costs.

Establishing a ceiling from an array of property expenditures is a way to contain payment for unnecessarily high property expenditures. Further, the system could disallow refinancing costs unless the proceeds were spent on

the facility to ensure that increases in financing costs passed onto the state represent real improvements in the property.

This approach would offer a modest advance over the current system in that the disincentives for capital improvements would be lessened for facilities between the floor and the ceiling. Further, the system is still very simple and could be developed using currently available data.

3. Fair Rental System

The term "fair rental system" has been applied to a wide variety of nursing home capital reimbursement systems, many of which have little in common. Here we are using the term to refer to a system in which the key feature is a rate based primarily on the appraised value of a facility, updated periodically. In Minnesota and Maryland, for example, property rates are computed by multiplying the "defined equity" (appraised value minus allowable debt) of a facility by a "rental factor" (5.33 percent in Minnesota, 9.7 percent in Maryland). In those states, allowable interest (which is subject to some limits) is treated as a passthrough.

The appeal of a "fair rental system" is that it recognizes the current value of a facility, can be designed to encourage desirable capital improvements and good maintenance and appears to some to be more equitable.

There are, however, substantial negative features from a state's perspective of fair rental systems as we are using the term. First, assuming that there continues to be some inflation, a straight rental system will always produce increasing property reimbursement rates and increasing state costs, while a system that pays "costs" will have declining reimbursement rates for facilities that are not resold. To some, this cost-increasing feature is only fair; to others, it represents unnecessary state expenditures and overstates the true opportunity costs of owning and maintaining a nursing

home. While the appraisal does give the value of a facility in terms of bricks and mortar (for example in terms of its replacement value), the appraisal does not truly reflect what the facility could earn, short of staying in the Medi-Cal program ("opportunity costs"). Many homes with high appraised value may have very low opportunity costs since a nursing home building itself is a single use structure. Alternative uses of the land for a hotel or apartment building will not be feasible or viable in many neighborhoods.

A second problem with fair rental systems is the need to appraise all facilities at least once and to devise an equitable system for updating their value. These problems are obviously not insurmountable, but would add to the administrative costs of a system.

Finally, establishing an appropriate "rental factor" has proven to be a highly contentious matter that is difficult at best for well-informed legislators to arbitrate or fair-minded administrators to resolve. While having an apparent simplicity about it, the concept of the rental factor is in fact quite complex: a relatively low rental factor can nevertheless produce extremely high rates of return on investment, depending on (among other things) the capital structure of a home, inflation, and the residual value on sale price of a home which is, in turn, partly a function of the reimbursment system. For example, Exhibit 46 below shows the sensitivity of the before tax rate of return on equity to the rental factor and percent of a home that was financed. The model assumes that general inflation is 4 percent per year and real estate inflation is 3 percent per year. These are very conservative assumptions; higher real estate inflation rates would increase the return. The model also assumes that the facility is held for 18 years and then sold for its replacement cost at the time. The "nominal" rate of return is the rate of return unadjusted for inflation and may appropriately be compared to interest rates on a savings account, though of course one would expect a higher return on a nursing home investment (deciding how much higher is "fair" is one of the difficult aspects of developing a rental system).

Exhibit 46

SENSITIVITY OF THE INTERNAL RATE OF RETURN TO THE RENTAL FACTOR AND THE PERCENT OF MORTGAGE FINANCING ON A NURSING HOME

Percent Financed	Return	Rental Factor 6%	8%	10%
65%	Nominal	9.8%	11.9%	14.0%
	Real	5.6	7.6	9.6
75%	Nominal	10.7	12.8	15.0
	Real	6.4	8.5	10.6
85%	Nominal	12.1	14.4	16.7
	Real	7.8	10.0	12.2

Source: Lewin and Associates simulations.

As the table above indicates, highly levered homes do better under rental systems such as those in Maryland and Minnesota when the measure of "doing well" is the internal rate of return. Thus, a fair rental system that pays the same "rental rate" to all facilities will result in substantially higher returns than necessary (to meet the states' objective) for some if the rental factor is set high enough to satisfy others. This makes the selection of an appropriate rental factor for a state extremely difficult.

Another consideration in selecting a rental factor is the overall degree of profitability on both capital and operating costs that is provided by the reimbursement system as a whole. The Exhibit 47 below illustrates the case of a home with 75 percent financing, capital costs of $25,000 per bed, 95 percent occupancy, and the same conservative inflation assumptions as in the previous exhibit.

Exhibit 47

BEFORE TAX INTERNAL RATE OF RETURN FOR COMBINED OPERATING AND CAPITAL REVENUE NURSING HOME WITH 75 PERCENT FINANCING

Rental Factor	Return	Net Operating Cost Revenue Per Patient Day $0	$1.00	$1.50	$2.00
6%	Nominal	10.7	14.9	17.1	19.2
	Real	6.4	10.5	12.6	14.6
8%	Nominal	12.7	16.9	19.0	20.9
	Real	8.4	12.4	14.4	12.8
10%	Nominal	14.6	18.8	20.7	22.5
	Real	10.2	14.2	16.1	17.8

Source: Lewin and Associates simulations.

As can be seen, a home that cleared $2.00/patient day on operating costs could have a 19.2 percent internal rate of return (given the specified assumptions) with a rental factor of 6 percent. This further illustrates the difficulty of selecting a fair and appropriate rental factor. The rental factor of "6 percent" seems very low when equated with interest rates on a savings account. But the number that is most comparable in this example to the savings account analogy is 19.2 percent.

The exhibits above are based on simulations that assume that interest costs are treated as a pass-through. A fair rental system without this feature but which paid the same rental factor to all facilities, regardless of actual capital expenditures, could be extremely costly for a state. It would have to set the rental factor high enough to ensure that a substantial portion of facilities serving Medi-Cal patients had rates sufficient for them to meet their mortgage obligations. This rental rate would in turn mean paying substantially higher returns than "necessary" to homes with low actual expenditures, e.g., those that were only minimally leveraged.

4. A Blended System

We recommend that California give particularly serious consideration to the development of a capital reimbursement system that blends elements of a purely cost-based system with elements of a fair rental system. Such a system might include the following features:

- Appraise all facilities; establish a maximum allowable appraised value (an investment per bed limit);

- Compute each facility's allowable property costs (e.g., interest, depreciation, taxes);

- For each facility, compute the ratio of costs per allowable appraised value; examine the distribution of these ratios;

- Establish an upper limit, based on an examination of the distribution and reasonable assumptions about financing. For example, suppose the 70th percentile were 15 percent (i.e., costs per appraised value equal .15). Is this a "reasonable" limit that would allow for some modern construction? The answer is "probably"; assume a building at $1 million, 10 percent down, 11 percent financing, 30-year depreciation, then annual costs in the early years equals 13-14 percent of appraised value.

- Based on similar considerations as well as simulations, total Medi-Cal expenditures set a "floor" at some point on the low end of the distribution of ratios (costs per allowable appraised values).

- Facilities above the ceiling are paid at the ceiling; facilities below the floor get to keep part of the difference between their costs and the floor; all other facilities get their costs.

- Appraisals can be updated by an index with periodic reappraisals.

This system eliminates two very negative features of the "pure" fair rental system: costly (to the state) "windfalls" paid to facilities with very low costs are substantially mitigated and there is no need to settle on a rental factor. At the same time, the system does incorporate some recognition of the current value of facilities.

Monitoring Access of Medi-Cal Patients to Care Should be an Ongoing Activity

As noted in Chapter III there are indications of a general deterioration in access to nursing home care by Medi-Cal beneficiaries. This situation needs to be carefully monitored by the state. The following are activities that could be undertaken to track changes in bed supply and access by Medi-Cal patients.

- Collecting patient-specific information on administrative day patients awaiting placement in hospitals.

- Repeating periodically a survey of hospital discharge planners to highlight problems in access of selected kinds of patients and in particular areas in the state.

- Collecting patient assessment information on a subset of patients in residential care facilities and at home (using community support services) to ascertain the levels of acuity of these individuals compared to patients in nursing homes.

- Keeping track of the distribution of Medi-Cal patients among facilities to determine whether their concentration in high Medi-Cal facilities is increasing or decreasing.

- Requiring ongoing progress notifications by those who file intentions to build or add beds so that the state has current information on how many new beds are actually in the pipeline.

Summary of Specific Recommendations

1. The state should begin the development of a method for reimbursing the capital component of the rate.

2. The state should implement a series of ongoing activities to monitor access problems of Medi-Cal patients.

CHAPTER VI: OVERALL LEVEL OF CALIFORNIA'S NURSING HOME RATES

As indicated in Chapter III, California had controlled its Medi-Cal expenditures on nursing homes more successfully than many other states during the late 1970s and early 1980s. The fact that the number of Medi-Cal patient days has not increased during the 1980s has had an obvious cost controlling impact as has the flat rate reimbursement system.

The augmentations resulting from the SB 53/AB 180 reform legislation in 1985 were a noticeable break in a pattern of very moderate rate increases during the 1980s. Exhibit 48 shows the rate increases for the 60-299 bed SNF geographical classes and demonstrates the large increases in 1985.

Exhibit 48

VARIABILITY IN RATE INCREASES
(SNF: BED SIZE 60-299)

	Los Angeles		Bay Area		All Other	
	Rate	% Growth From Prior Year	Rate	% Growth From Prior Year	Rate	% Growth From Prior Year
8/1/80	$34.52		$36.86		$34.52	
8/1/81	35.33	2.4	38.19	3.6	35.26	2.1
8/1/82	36.10	2.2	39.22	2.7	36.08	2.3
8/1/83	36.85	2.1	40.66	3.7	37.06	2.7
8/1/84	39.09	6.1	43.06	5.9	39.43	6.4
8/1/85	44.67	14.3	50.02	16.2	46.20	17.2
8/1/86	44.67	0	51.25	2.5	46.66	1.0
8/1/87	46.76	4.7	53.76	4.9	48.24	3.4

Source: Department of Health Services Reimbursement Studies.

Concerns about providing adequate quality of care motivated the 1985 augmentations which were targeted through a labor passthrough to increasing expenditures on nonadministrative personnel. The Legislature has been unwilling for nearly a decade to pass nursing home augmentations, except for annual cost of living increases, that were not tied in some way to expected improvements in quality of care.

Nursing home providers have continually argued that if the state is genuinely concerned with quality of care it should provide facilities with additional resources through higher Med-Cal rates. While preferring unrestricted funds, they have become resigned to the unwillingness of the

state to support augmentations that are not targeted to quality improvements. In fact, a segment of the nursing industry itself supported such legislation during the 1987 legislative session (AB 1272). They have argued vehemently, however, against any targeting through control language of the annual cost of living adjustment (COLA) in the budget.

There Is a Wide Range in Profitability on Medi-Cal Patients Among Facilities

In our analysis of 970 SNF facility 1985 cost reports, we compared the rates received for Medi-Cal patients to the average cost per day reported by the facility. (The reported costs were reduced by 4 percent to account for an estimated adjustment for Medi-Cal nonallowable costs, generally determined by the Department of Health Services audits to be around 4 to 5 percent.) Overall total Medi-Cal payments to facilities (i.e., the total rate for each facility multiplied by the total Medi-Cal days) were greater than total facility expenditures on Medi-Cal residents. Thus the system as a whole is providing a net positive margin to the industry.

The results of this analysis, shown in Exhibit 49, indicate that 54.5 percent of the facilities earned a positive margin on their Medi-Cal patients, i.e., their Medi-Cal rate per day was higher than their allowable average cost per day. This result should not be surprising since the use of a median flat rate system should result in about half the facilities earning positive margins and half not.

Of greater interest is the distribution of margins by Medi-Cal days and the wide variation in the extent of positive and negative margins. More Medi-Cal patients are in facilities that earn a positive margin on Medi-Cal patients so that while 54.5 percent of facilities earn a positive margin, 68 percent of the Medi-Cal patient days result in a positive margin (as shown in the right columns on Exhibit 49). There is substantial variation with

17.2 percent of the Medi-Cal days resulting in positive margins of more than 10 percent and 10 percent resulting in negative margins of more than 10 percent. The 32 percent of the Medi-Cal patient days that have costs higher than the Medi-Cal rate must be subsidized by private pay patients. The average (mean) subsidy was $4.30 per patient day (median = $2.57 per patient day).

Exhibit 49

PERCENTAGE OF FACILITIES EARNING DIFFERENT MARGINS ON MEDI-CAL PATIENTS (1985)

Margins	Percent of Facilities		Percent of Medi-Cal Days	
	%	Cumulative %	%	Cumulative %
Medi-Cal rate more than 10% greater than average costs	12.8		17.2	
Medi-Cal rates between 5-10% greater than average costs	20.1	32.9	25.0	42.2
Medi-Cal rates between 0-5% greater than average costs	21.6	54.5	25.8	68.0
Medi-Cal rates between 0-5% less than average costs	14.3	68.8	14.1	82.1
Medi-Cal rates between 5-10% less than average costs	88.5	77.3	7.7	89.8
Medi-Cal rates more than 10% less than average costs	22.7	100.0	1.02	100.0

Note: The data in this analysis includes a 4% reduction in all facilities' costs as reported to account for an estimated adjustment for Medi-Cal nonallowable costs, generally determined by Department of Health Services audits to be around 4 to 5%.

Source: Lewin and Associates cost analysis.

Redistribution of Medi-Cal Expenditures Can Better Target Funds to Meet State Objectives

If the state adopts our basic recommendation of a facility-specific cost centered approach it should be possible to redistribute some Medi-Cal dollars from facilities earning large positive margins to provide some relief to those facilities who have negative margins because of higher than average expenditures on patient care-related items. As indicated in the discussion of Recommendation A in Chapter V the patient care related ceiling could be set as high as 75 to 80 percent without requiring the state to spend additional funds.

California Spends Fewer Medicaid Dollars on Nursing Homes per Elderly Resident Than Other States

Data from 1980 showed that California ranked 38 out of 50 states in Medicaid expenditures on nursing home care per elderly resident in the state. More recent comparisons from 1985 show California considerably below other major states on this same measure, as shown in Exhibit 50.

Exhibit 50

COMPARISON OF CALIFORNIA'S MEDICAID NURSING HOME EXPENDITURES PER ELDERLY RESIDENT WITH OTHER MAJOR STATES (1985)

	Expenditure per Elderly Citizen Aged 65+	Expenditure per Elderly Citizen Aged 75+	Expenditure per Elderly Citizen Aged 85+
California	$423	$1064	$4437
Michigan	576	1465	6135
Illinois	499	1230	5095
Pennsylvania	640	1625	7103
Florida	238	594	2960
Ohio	550	1373	5656
Texas	467	1153	5167
New Jersey	575	1472	6309
Wisconsin	915	2138	8424
Massachusetts	851	2012	7744
Minnesota	1128	2528	9348
New York	1653	3969	16490

Sources: Statistical Abstracts; Bureau of the Census; Office of the Legislative Analyst

In general there is a strong relationship between these rankings and the ratio of nursing home beds per elderly in the state. As indicated earlier in the report these figures can be misleading since they do not consider the other resources devoted in California to residential care or community services for the elderly that live at home nor do they factor in differences in the age distribution and health status of the state's elderly population.

Some researchers and government officials periodically compile differences among the states in the daily rates paid for SNF and ICF care. California generally falls within the lower half in these listings in its

daily rate. We have not included any such listings in this report since in our experience they can be misleading and inaccurate. The wide variety in reimbursement systems makes comparisons of "average" rates a questionable practice.

California Will Face Some Cost-Increasing Pressures

There are pressures on the system that California policy makers will need to consider in determining the priority to be placed on Medi-Cal expenditures on nursing home care. The acuity of California's nursing home population appears to be increasing (Exhibit 23), which raises the resources that must be devoted to providing adequate quality of care. The health care system is undergoing major transitions that are reducing the amount of time that patients spend in acute care hospitals during an episode of illness or injury. Of greatest importance is the financial incentive that hospitals have under the Medicare Diagnostic Related Group (DRG) system to discharge patients earlier since they receive a set predetermined payment no matter how long the patient remains in the hospital.

The phenomenon of patients being discharged "quicker and sicker" is being noted throughout the country and was commented upon by virtually all the nursing home owners and operators we interviewed. A recent article in the Journal of the American Medical Association (July 10, 1987) documented a dramatic decrease in length of stay for elderly patients hospitalized for hip fractures at a university-affiliated municipal teaching hospital from 16.6 days before Medicare DRGs to 10.3 days after. The percent of patients discharged to nursing homes increased from 21 percent to 48 percent. The financial pressures on hospitals, in part caused by government payers such as Medi-Cal, is expected to continue, increasing their susceptibility to the financial incentives under Medicare to discharge patients sooner with higher care needs than in the past.

The labor markets for nurses and nurse aides are cyclical with periods of shortage that make recruitment and retention significant challenges for nursing homes. Nationally, the vacancy rate for registered nurses in hospitals more than doubled from 6.3 percent in 1985 to 13.6 percent in 1986.* Vacancy rates also increased in California during this time period from 6.4 percent to 8.9 percent. Nursing home operators we interviewed generally believe that the acute care market and the nursing home market for registered nurses are distinct, i.e., that most nurses work in either one or the other setting and do not switch back and forth. It is generally believed, however, that the trends that underlie the shortage for hospital R.N.s impact on nursing homes as well. While the number of graduates in California nursing programs has been gradually growing, the number of enrollees in these programs has declined from 16,000 in 1982 to 14,000 in 1986.

Nursing aides, who provide the majority of direct patient care, present an even more difficult recruitment and retention problem for some nursing homes. The extremely demanding nature of the work compared to other low wage employment makes these positions unattractive to most workers. Changes in the immigration laws may have a significant but indeterminate impact on the supply of nurse's aides in some communities. Stiffer employer sanctions might reduce the willingness to hire undocumented workers, thus shrinking the supply. The amnesty provisions might allow some nurse's aides a wider choice of employment opportunities, again reducing the potential supply.

Overall, the turnover of employees in California's nursing homes while high has been declining, from 134 percent in 1978, to 100 percent in 1981, to 91 percent in 1985. Similarly, the proportion of employees with more

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* California Association of Hospitals and Health Systems Insight, Vol. 11, Number 9, August 29, 1987.

than 12 months of service has increased from 47 percent in 1978, to 49 percent in 1981, to 56 percent in 1985.** Increasingly tight labor markets could make it more difficult to continue these positive trends. In our analysis of 1985 cost reports we found an inverse correlation between employee turnover and nursing wage rates (all nursing personnel) and nursing hours (all nursing personnel) per patient day suggesting that both higher wages and lower work load (through more employees) can have a positive impact on turnover.

Conclusion

The decision on the overall level of Medi-Cal expenditures on nursing home care is made within the context of considering all of California's other needs and priorities. California spends less per elderly resident than many other states, but as stressed throughout the report this fact is not definitive of the state's commitment since it does not consider other elements of community services for the elderly.

Medi-Cal rates have been sufficient to cover the costs of care for nearly 70 percent of the Medi-Cal patients, but as would be expected with a flat rate system set at the median of projected costs, nearly half the facilities have average costs for their Medi-Cal patients that exceed their rates. The state can accomplish a degree of redistribution of its expenditures by targeting more of the dollars on patient-related costs by adopting the recommendations in this report.

Two factors -- increased patient acuity and a potentially tighter nursing personnel labor market -- could place additional demands on nursing homes and will need to be considered by the state as it weighs its relative priorities.

** Office of Statewide Health Planning Aggregate Long-Term Care Facility Disclosure Data.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1248

October 14, 1987

Mr. Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Thank you for furnishing Health and Welfare Agency Secretary Clifford Allenby a draft copy of the Lewin and Associates report entitled "An Evaluation of the Medi-Cal Program's System for Establishing Reimbursement Rates for Nursing Homes" for review and comments. Secretary Allenby forwarded it to the Department of Health Services for response since we have program responsibility.

The report makes many specific recommendations, some of which the Department agrees with or has already implemented, some which the Department believes deserve further exploration, and others which cause us serious concern.*

Our initial review has concentrated on the recommendations of the report. Specifically, we are concerned about two of their central recommendations:

1. One point stressed throughout the report is that their recommendations will be "budget neutral". We believe this would be impossible considering the current political environment and the economic realities of the long term care industry. The proposed system institutes a new level of care, higher than skilled nursing, which would account for 10 percent of the current nursing home patient population. For these patients there would be additional reimbursement. The purpose for this new level of care, according to the report, would be to lessen the current load of administrative day patients, i.e., those who are unacceptable to facilities due to their alleged higher level of care needs or for which there are no beds. We disagree that such a proposal fits into a "budget neutral" concept because (a) some rates of the other patients would have to be reduced (not a "political feasibility" as required by the RFP); (b) with nursing home occupancy running approximately 95 percent statewide, and closer to full occupancy in many areas, there are few, if any, beds for the administrative day patients, even if the state could convince facilities to accept them for a higher rate; and (c) in addition, and more importantly, the introduction of a new level of care, at a higher rate, would provide a disincentive for health maintenance and would provide an incentive for grade creep. The state would end up paying more money in future years to take care of the same nursing home patients.

*The comments of Lewin and Associates, Inc. on the department's response begin on page 181.

2. The report also proposes a facility specific rate, based on costs. Even if the recommendations could be implemented in a budget neutral manner, we assume that the report is referring only to Medi-Cal program dollars and not the State's administrative costs. The report states that, under such a system "accurate and consistent cost reports will be absolutely essential". The state currently audits approximately 20 percent of the nursing homes annually (the report stated 15 percent). To conduct these audits requires 32.75 person years of time. A facility specific system would require a 100 percent audit of facilities, necessitating a field and support audit staff increase of approximately 100 full time positions. In addition, establishing another level of care would require closer surveillance of patients and their potential for changing level of acuity. This would require additional nursing staff in our Medi-Cal field offices. Finally, the headquarters administrative costs would increase significantly, as the Rate Development Branch would require additional staff to develop facility specific rates. In total, we see the possible need for 140 to 150 additional State staff at a cost of over $6 million.

The Department has recognized for some time that the provision of high quality long term care services for Medicaid recipients, at an affordable price, is a complex national problem not confined to California. We have also recognized that reimbursement systems can play an important, but not the only role, in solving some of these problems. Accordingly, we obtained additional staff this year to review some of our long term care rate setting processes, including our peer grouping classification system. We anticipate that these studies will eventually lead to a rebasing of our current rate setting system and provide many of the benefits of a facility specific system as outlined by the report, at a fraction of the administrative costs. We are also closely examining the reimbursement system used by the state of Illinois (the QUIP system) in their Medicaid program, which provides for quality incentives.

In addition, the Health and Welfare Agency is, as part of budget act language, studying the organization and financing of the State of California's long-term care delivery system.

For the reasons above we cannot support the major recommendations of the report and do not believe it would be appropriate at this time to make any major changes in the manner nursing home rates are established.

We would be happy to meet with you or your staff and the Lewin consultants to discuss our comments in more detail. Should you have any questions, they can be directed to Richard P. Wilcoxon, Chief, Medi-Cal Policy Division at (916) 445-6141.

Sincerely,

Kenneth W. Kizer, M.D., M.P.H.
Director

LEWIN & ASSOCIATES COMMENTS ON THE DEPARTMENT OF HEALTH SERVICES' RESPONSE

We appreciate the Department's concern about making "any major changes in the manner [in which] nursing home rates are established." The current flat rate system has been in effect for many years, and accommodations have been made to it. Implementing change, particularly in a state as large and complex as California, can be difficult. Therefore change, merely for the sake of trying something new, would be unwise state policy. But the difficulty that change entails, in our view, should not stand in the way of the state's adopting new approaches that better meet its goals and objectives.

Substantial concern exists about the quality of care within the state's nursing homes, and yet the current reimbursement system does not encourage spending on patient related items. This is a major problem which the state can ameliorate by altering its reimbursement method, even if it entails some disruption in the system in the interim. We have been mindful throughout our work of the reluctance on the part of many to alter the current system and have moderated our recommendations on this account. Given this resistance to change, the work on system modifications the Department is engaged in, and the general importance of the issue, we certainly concur that no precipitous actions should be taken. We would hope and anticipate that our recommendations would become part of the legislative debate and deliberations, along with any ideas and proposals that the Department generates as part of its review.

For the sake of brevity, we are limiting our comments to three general areas:

- New level of care
- Administrative costs
- Budget neutrality

A New Level of Care That Is Needed for Quality of Care Reasons Can Be Implemented Reliably and Fairly

We proposed the development of a higher rate for a limited subset of residents with special care needs to increase their access to appropriate care and to better ensure that facilities have sufficient resources to care for them. It is possible that the state may be able to reduce expenditures for administratively necessary days if more of the hard-to-place residents can be placed sooner, but this was not the only goal of the special care rate proposal.

We agree with the Department that the institution of a higher, special care rate for a selected set of residents would require careful utilization review to ensure that only those residents whose needs met criteria were certified for the rate and that quality of care were maintained. With regard to possible "disincentive(s) for health maintenance" attendant on paying higher rates for residents whose care is more costly, we note that at present the lack of sufficient resources to cover the cost of caring for these residents is a serious disincentive to appropriate care.

If paying a higher rate for more costly residents did create a positive incentive for nursing homes to "keep residents sick" (there is no empirical evidence that such occurs), we are confident that the Department would be fully capable of developing cost-effective administrative systems to counter this disincentive as have other states. (The report includes suggestions for administering the special care rates.)

The current Medi-Cal reimbursement system creates extremely strong incentives for nursing homes to 1) avoid taking sicker Medi-Cal residents at all, and 2) spend as little as possible on the residents they do take. The system we have recommended does not allow profit for facilities on the direct care component that would be supplemented under the special care rate. Thus, the proposed approach removes the disincentive for accepting very heavy care patients and prevents the facility from profiting from spending less on patient care. The risk of inappropriate incentives is far greater in the current system than in the one we propose.

Any Increase In Administrative Costs Are a Necessary Part of Attaining a System with Greater Accountability

As indicated in our report, in order to establish the flat rate, accuracy of cost reporting at the facility specific level is not necessary. There are no consequences in terms of its specific rate for a facility with errors in its cost report. Any effort to establish more facility specific accountability will entail some increase in administrative costs. The labor passthrough approach has demonstrated this. The number of hours to audit facilities for compliance with the labor passthrough is currently equivalent to what is required for a full rate audit. As a consequence of

the increased anticipated workload, the Department is planning to audit only about 5% of the facilities on the labor passthrough in the upcoming year. Given the 11-12% errors found in the first group of audited facilities, this restriction in audit activity may be costing both the state and employees substantial dollars in recoupment from the 95% of the facilities that will not be audited.

The above merely demonstrates that additional administrative costs are necessary to make the current system accountable at a facility specific level. This is true whether the state maintains the current flat rate system with the labor passthrough or moves to something like our recommended facility specific cost component method. This is a tradeoff of administrative costs for greater accountability which, in our view, is clearly worth the investment. Absent facility specific accountability, the state has no way to ensure that funds are being expended as allowed and/or desired. The additional administrative costs are the price for creating a reimbursement system that contains incentives for greater expenditures on direct patient care and enhanced quality. In an almost $1 billion system of care, the $6 million figure estimated by the Department for increased administrative costs (even if it were correct) would represent the equivalent of about a 1% increase in the current rates (in General Fund dollars) and, in our view, would contribute substantially to the accountability of not only additional rate increases but also of the base rate.

What is recommended in our report is accomplished by nearly every other state which periodically field audit all the cost reports in order to establish base rates on a facility specific basis. The Department, in our view, may overexaggerate

the difficulty of implementing our recommendations. As we indicate in the report, the actual detailed design and initial implementation of the system will require additional resources, but the ongoing operation should be no more resource intensive than the current system.

The Recommended System Can Be Designed to Achieve Any Desired Level of Overall Expenditures Including Budget Neutrality

Our report accurately states that the system changes we propose could be budget neutral, depending on where precisely the state chose to set specific parameters for the limits and efficiency incentives. We did not make a specific recommendation about the absolute level of reimbursement that should be dedicated to Medi-Cal nursing home residents because that decision must take into account the competing obligations of the state.

It should be noted, however, that the current Medi-Cal reimbursement method is by no means budget neutral. Rates for nearly all facilities have been increased every year, with substantial augmentations through the labor passthrough in the attempt to target funds on patient care. But under the current flat rate reimbursement system, a substantial proportion of these rate increases and total Medi-Cal expenditures have gone to increase or maintain the level of surplus revenues for some facilities that spend very little indeed on resident care. The system we propose is designed to better target the state's resources to promote access and quality of care.

As noted in our report, the care needs of Medi-Cal nursing home residents are demonstrably increasing. This trend should continue, as it is sound public policy to reserve nursing home

beds for those with the greatest needs while increasing efforts to care for the less disabled in the community. Providing for increased needs at even the same level of quality requires higher expenditures on resident care at some point. But it is imprudent, in our view, simply to increase rates without accountability. The choice for California as we see it is between holding onto the present system which (absent the labor passthrough) is admittedly simple and cost-constraining, but which lacks fundamental accountability, or to adopt a reimbursement system which permits more careful targeting of state resources.

APPENDIX A:
OVERVIEW OF THE RESIDENT ASSESSMENT STUDY

Appendix A

OVERVIEW OF THE RESIDENT ASSESSMENT STUDY

The data on resident acuity and care needs discussed in this report are derived from a study conducted in June and July of 1987.

The Sample of Facilities

A stratified random sample of hospitals was selected: 20 percent of all freestanding nursing homes (excluding state-owned and those specializing in care for persons with mental retardation) and 50 percent of hospital-attached facilities. Exhibit A.1 shows the distribution of sample facilities and the response rate by detailed geographic, size, and ownership groupings. The overall response rate was 56 percent for the freestanding facilities and 49 percent for the hospital-attached facilities, resulting in a final sample of 150 freestanding facilities and 21 hospital-attached.

The Sample Residents

Assessment data were collected on 50 percent of the residents in all freestanding facilities, except for those exceeding 300 beds, in which a 25 percent sample was drawn. Hospital distinct part units with fewer than 30 beds (all but the government facilities) were instructed to conduct assessments of 100 percent of the residents. Larger distinct part units followed the sampling procedures of the freestanding facilities.

Usable assessment information was obtained on 884 residents of distinct part units. As can be seen in Exhibit A-1a, the proportion of survey residents in county facilities (37.2%) was somewhat lower than the proportion of total patient days (58.1%) attributable to residents

of county facilities in 1986. We do not view this as in any way problematic, as it is likely that the proportion of county patients is declining and the actual number (329) of county patients in the sample was reasonable.

From the freestanding facilities, usable case-mix information was obtained for 6,160 residents, of which 6 percent (385) were ICF and 94 percent (5,775) were SNF. As can be seen in Exhibit A-1b, the distribution of sample residents by payor closely matched that of the distribution of patient days (1986) by payor.

The Assessment Process

An assessment instrument (Exhibit A-2) was developed with the assistance of the San Francisco Medi-Cal field office staff, the California Association of Homes for the Aged, the California Association of Health Care Facilities, and the California Hospital Association.

The resident assessments were done by the nursing staff of the participating facilities. Medi-Cal field office staff verified a 10 percent sample of the assessments.

Exhibit A. 1

DISTRIBUTION OF SAMPLE FACILITIES BY SIZE, GEOGRAPHIC AREA, AND OWNERSHIP

		TOTAL	SAMPLE	RETURN
SNF 1-59 COUNT				
AREA 1	IO	69	13	5
	NP	29	7	3
	PUB	0	0	0
	UNKNOWN	3	0	0
	TOTAL	101	20	8
AREA 2	IO	71	11	5
	NP	25	7	3
	PUB	0	0	0
	UNKNOWN	2	1	0
	TOTAL	98	19	8
AREA 3	IO	112	24	13
	NP	42	10	6
	PUB	1	1	0
	UNKNOWN	6	0	0
	TOTAL	161	35	19
TOTAL	IO	252	48	23
	NP	96	24	12
	PUB	1	1	0
	UNKNOWN	11	1	0
	TOTAL	360	74	35
SNF 60-299 COUNT				
AREA 1	IO	215	48	21
	NP	25	6	2
	PUB	0	0	0
	UNKNOWN	18	4	1
	TOTAL	258	58	24
AREA 2	IO	95	20	11
	NP	14	0	0
	PUB	0	0	0
	UNKNOWN	11	3	1
	TOTAL	120	23	12
AREA 3	IO	295	67	53
	NP	20	6	5
	PUB	1	1	1
	UNKNOWN	19	3	2
	TOTAL	335	77	61
TOTAL	IO	605	135	85
	NP	59	12	7
	PUB	1	1	1
	UNKNOWN	48	10	4
	TOTAL	713	158	97

IO = Investor owned
NP = Not for profit
PUB = Government owned

AREA 1 = Los Angeles
AREA 2 = Bay Area
AREA 3 = Other

		TOTAL	SAMPLE	RETURN
ICF 1-59 COUNT				
AREA 1	IO	7	5	2
	NP	5	1	0
	PUB	0	0	0
	UNKNOWN	1	0	0
	TOTAL	13	6	2
AREA 2	IO	8	2	1
	NP	7	3	2
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	15	5	3
AREA 3	IO	32	7	3
	NP	10	2	2
	PUB	0	0	0
	UNKNOWN	4	0	0
	TOTAL	46	9	5
TOTAL	IO	47	14	6
	NP	22	6	4
	PUB	0	0	0
	UNKNOWN	5	0	0
	TOTAL	74	20	10
ICF 60-299				
AREA 1	IO	4	3	2
	NP	3	3	0
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	7	6	2
AREA 2	IO	2	1	0
	NP	0	0	0
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	2	1	0
AREA 3	IO	2	2	2
	NP	2	2	2
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	4	4	4
TOTAL	IO	8	6	4
	NP	5	5	2
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	13	11	6

		TOTAL	SAMPLE	RETURN
SNF 300+ COUNT				
AREA 1	IO	1	0	0
	NP	0	0	0
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	1	0	0
AREA 2	IO	0	0	0
	NP	1	1	1
	PUB	1	0	0
	UNKNOWN	0	0	0
	TOTAL	2	1	1
AREA 3	IO	4	2	1
	NP	0	0	0
	PUB	0	0	0
	UNKNOWN	0	0	0
	TOTAL	4	2	1
TOTAL	IO	5	2	1
	NP	1	1	1
	PUB	1	0	0
	UNKNOWN	0	0	0
	TOTAL	7	3	2
TOTALS				
AREA 1	IO	296	69	30
	NP	62	17	5
	PUB	0	0	0
	UNKNOWN	22	4	1
	TOTAL	380	90	36
AREA 2	IO	176	34	17
	NP	47	11	6
	PUB	1	0	0
	UNKNOWN	13	4	1
	TOTAL	237	49	24
AREA 3	IO	445	102	72
	NP	74	20	15
	PUB	2	2	1
	UNKNOWN	29	3	2
	TOTAL	550	127	90
TOTAL	IO	917	205	119
	NP	183	48	26
	PUB	3	2	1
	UNKNOWN	64	11	4
	TOTAL	1167	266	150

Exhibit A-1a

COMPARISON OF THE DISTRIBUTION OF DISTINCT PART RESIDENTS IN THE CASE-MIX SAMPLE

	DISTINCT PART SNFS				
	Total Patient Days 1986			Patients in Assessment Study (One-Day Sample)	
Ownership	%	(N)		%	(N)
Non-Profit	20.9%	(174,109)	;		
Investor-Owned	7.6%	(63,271)	=	62.8%	(555)
District	13.4	(111,664)	;		
County	58.7%	(482,083)		37.2%	(329)
Total*	100.0%	(831,127)		100.0%	(884)

* Excludes state facilities as these were excluded from assessment study.

Appendix A-1b

COMPARISON OF RESIDENTS IN FREESTANDING FACILITY CASE-MIX SAMPLE TO DISTRIBUTION OF PATIENT DAYS IN FREESTANDING FACILITIES BY TYPE AND PAYOR

	Patient Days in Freestanding Facilities 1986		Residents in Freestanding Facility Case-Mix Sample:	
Type	Payor	% of Days	% of Sample	(N)
SNF	Medicare	3.4%	3.4%	(210)
	Medi-Cal	65.9%	58.0%	(3,575)
	Other	30.7%	32.3%	(1,990)
	Total	100.0%	100.0%	(6,160)
ICF	Medicare	0.0%		
	Medi-Cal	75.7%	72.7%	(280)
	Other	24.3%	27.3%	(105)
	Total	100.0%	100.0%	(385)

1987 California Reimbursement Study Assessment Form

Sex _____ Birthdate _____ Admission Date _____ Room No._____ Patient Classification
Primary payor for this patient: Medicare _____ Medi-Cal _____ Other _____ Bed No._____ ICF _____ SNF_____
Signature of person completing form _____ Title _____

ICDA Code	Current Diagnosis

Activities of Daily Living*
**Mark either independent (1) Assistance with mechanical device (2) Assistance with a person (3) Assistance by person and device (4) or Totally dependent (5)*

___ Walking
___ Turning/Positioning
___ Dressing
___ Toileting
___ Transferring
___ Bathing
___ Grooming

Bowel Control (check one)
☐ Continent
☐ Involuntary-Taken to the Toilet
☐ Involuntary-Not Taken to the Toilet
☐ Occasionally involuntary
☐ Colostomy/Ileostomy

Bladder Control (check one)
☐ Continent
☐ Involuntary-Taken to the Toilet
☐ Involuntary-Not Taken to the Toilet
☐ Occasionally involuntary
☐ Catheter

Feeding (check one)
☐ Feeds self
☐ Feeds self w/assist. device
☐ Needs partial help in feeding
☐ Needs to be feed
☐ N-G Tube
☐ Gastrostomy
☐ Parenteral (TPN)
☐ Supplemental feedings

Visual (check one)
☐ No apparent handicap
☐ Severe visual impairment
☐ Correctable vision w/glasses
☐ Legally or totally blind

Auditory (check one)
☐ No apparent hearing problem
☐ Mild hearing problem
☐ Wears hearing aid
☐ Deafness, corrected by aid
☐ Deafness, not corrected

Social Support (check one)
How often does the patient interact with family or other social support? ☐ No family/social support
☐ Daily ☐ Weekly ☐ Monthly ☐ Less than Monthly

Decubitus Ulcer
☐ None or healed
Enter number of each type if applicable:
___ Stage I
___ Stage II
___ Stage III
___ Stage IV

Other Wound Care
☐ None or healed
Enter frequency if applicable:
1=Once /day; 2-=BID;
3=TID; 4=Other
___ Dry sterile dressing
___ Sterile/medicated dressing
___ Open, draining

Restorative Nursing
Enter frequency if applicable:
1= Once/day; 2=BID; 3=TID; 4=More often
___ Patient teaching by licensed staff
___ Reality orientation/rem. therapy
___ Range of Motion
___ Ambulation

Patient's Current Condition (check one)
☐ Stable ☐ Unstable ☐ Terminal

Clinical Monitoring (check one)
Clinical monitoring includes nursing procedures emanating from the resident's diagnosis and medically unstable and/or high risk condition(s). Procedures include temperature, pulse, respiration, blood pressure, weight, urinalysis, intake and output. Include other recorded monitoring such as observation for edema, drug reactions.

☐ Once a day or less
☐ Monitoring on every shift
☐ One or two shifts a day

Special Needs/Treatments
Enter frequency if applicable:
1= Once/day; 2=BID;
3=TID; 4=More often
___ Inhalation/Oxygen therapy
___ Suctioning
___ Crushed meds
___ Physical therapy-restorative
___ Speech therapy
___ Tracheostomy care
___ Injections
___ Whirlpool
___ Occupational therapy
___ Stasis Ulcer

Other Special Needs/Treatment
Check those that apply:
☐ Transfusions
☐ Comatose
☐ Traction
☐ Postural supports
☐ Dialysis
☐ I.V. hydration
☐ Post-operative patient (less than 1 week)
☐ Frequent seizures (more than one week)
☐ Frequent M.D. visits (more than 1 week)
☐ Internal bleeding
☐ Spasticity
☐ Contractures
☐ Behavorial restraints
☐ Ventilator dependent
☐ I.V. therapy (e.g., antibiotic, chemotherapy)
☐ Scheduled pre-operative patient
☐ Infection control/isolation procedures
☐ Chemotherapy (e.g., oral/I.V.)

Communication (check one)
☐ Communicates needs without assistance
☐ Communicates needs with difficulty but can be understood
☐ Communicates needs with sign language, symbol board, written messages, gestures, or an interpreter
☐ Communicates inappropriate content, makes garbled sounds, or displays echolalia
☐ Does not communicate needs

Behavior (check one)
☐ Behavior requires no intervention

☐ Behavior requires occasional staff intervention in the form of cues because the resident is anxious, irritable, lethargic or demanding. Resident responds to cues easily.

☐ Behavior requires frequent staff intervention in the form of re-direction because the resident has episodes of disorientation, hallucinates, wanders within the facility, is withdrawn or exhibits similar behaviors. Resident is resistive, but responds to re-direction.

☐ Behavior presents management problems and requiries consistent staff intervention because resident exhibits disruptive behavior such as verbally abusing others, wandering into private areas of the facility and removing or destroying property or acting in a sexually aggressive manner. Resident is resistent to re-direction and often does not respond.

☐ Behavior presents management problems and requires constant staff intervention because resident is physically abusive to self and others. Resident physicially resists re-direction.

APPENDIX B:
OVERVIEW OF HOSPITAL DISCHARGE PLANNERS SURVEY

OVERVIEW OF HOSPITAL DISCHARGE PLANNERS SURVEY

A survey of hospital discharge planners was conducted to obtain information about access to post-hospital care for Medi-Cal beneficiaries. We were seeking information about the types of problems, if any, discharge planners had in placing patients and differences between hospitals with distinct part units and those without distinct part units. Although this survey is not statistically representative of hospitals across the state, it provides anecdotal information that supplements the Resident Assessment Study obtained from the survey of nursing home patients.

Discharge planners in fourteen hospitals with distinct part units and fifteen hospitals without distinct part units were selected for interviews (total = 29 hospitals).

Exhibit B.1 shows the following characteristics of the hospitals that were selected:

- County
- Bed Size (less than 200 beds, 200-400 beds, greater than 400 beds).
- Ownership (government/non-federal, federal, non-profit, and for-profit).

Responses to two key questions regarding access are presented in Exhibits B.2 (Hospitals with Distinct Parts) and B.3 (Hospitals without Distinct Parts). Exhibit B.4 summarizes results of discharge planners' quantitative assessment of the relative difficulty of placing different patient types. A copy of the interview guide follows these exhibits.

Exhibit B.1

CHARACTERISTICS OF HOSPITALS SURVEYED

Ownership[1]	County	Bed Size Group[2]
Distinct Part		
Non-Profit	San Francisco	2
Non-Profit	Sacramento	2
Non-Profit	San Francisco	3
Non-Profit	Hayward	1
Non-Profit	San Jose	2
Non-Profit	Modesto	2
Non-Profit	Los Angeles	1
Non-Profit	Santa Cruz	2
Non-Profit	Bakersfield	2
Non-Profit	Susanville	2
Non-Profit	Oxnard	2
Government/Non-Federal	Stockton	2
Government/Non-Federal	Fresno	2
Government/Non-Federal	Sonoma	1
No Distinct Part		
Non-Profit	San Jose	2
Non-Profit	Redding	1
Non-Profit	Sacramento	3
Non-Profit	Lakeport	1
Non-Profit	San Jose	2
Non-Profit	Lodi	1
Non-Profit	San Jose	2
For-Profit	Anaheim	1
Non-Profit	Bakersfield	3
Non-Profit	Santa Rosa	2
Non-Profit	Watsonville	1
Non-Profit	St. Bernadino	3
Government/Non-Federal	Oakland	2
Government/Non-Federal	Los Angeles	3
Government/Non-Federal	Ventura	2
Federal	Riverside	2

[1] Classifications obtained from the AHA Guide, 1987 edition.

[2] §200 beds = 1; 200-400 beds = 2; 400+ beds = 3.

Exhibit B.2

RESPONSES TO SELECTED QUESTIONS IN THE SURVEY OF HOSPITAL DISCHARGE PLANNERS:

HOSPITALS WITH A HOSPITAL DISTINCT PART UNIT

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital A	Yes, it has definitely gotten worse for Medi-Cal patients. Also, sometimes they call for preauthorization, and the state later changes their mind. They recently opened a distinct part unit last March. One of the main reasons they opened this unit is because they have a hard time placing IV patients.	Any patient that needs equipment is hard to place. For a Medi-Cal patient, who is not a dual eligible (commonly called a Medi-Medi), facilities receive a skilled rate of $44 to pay for everything, including equipment. Therefore, they don't want these patients. Facilities would be more willing to take a Medi/Medi patient with heavy needs because Medicare would pay for the equipment. He would have no problem placing a Medi-Cal patient that only needed a wheel chair, if the patient didn't need any other equipment. Even foley catheters and NG tubes are considered undesirable. Most SNFs also don't want to take patients with IVs or hyperalimentation.
Hospital B	Yes, Medi-Cal patients are hard to place.	AIDs patients are the hardest to place, and he predicts that this will get worse. Right now he is trying to place a 68 year old woman who contracted AIDs from a blood transfusion. She has both Medicare and Medi-Cal, but her current care needs are custodial, and thus is Medi-Cal only. Patients with Alzheimers, particularly those that are noisy and combative are also difficult to place.
Hospital C	Medi-Cal patients are difficult to place, but not patients that have money.	Straight Medi-Cal patients. She feels nursing homes are not getting enough money to take care of Medi-Cal patients. Medi-Cal heavy care and maximum assist patients. Especially tube feeders, confused patients, and stroke patients. Also respirator dependent and trach patients.

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital D	Yes. This is mainly due to the condition of the patient.	Total care patients. Tracheotomy. NG tube. Decubitus ulcers. Behavior problems such as verbally aggressive, loud and demanding patients. On occasion, patients will be hard to place because of financial problems. Patient not eligible for Medi-Cal but doesn't have enough money to pay the nursing home.
Hospital E	Yes, they have a lot of problems with placing patients. It is almost impossible to place a Medi-Cal patient. A town 40 miles away is as close as they can get. They sometimes have to go to a town 100 miles away.	A total care patient with an NG tube. Nursing homes in California get fines if a patient gets worse. Therefore, they don't want to take a decubitus patient because they will get fined if the patient gets worse. The fines can be as high as $10,000 or $25,000.
Hospital F	Yes, especially for straight Medi-Cal patients. Sometimes it eases up a little but in general it's difficult. They need more SNFs that will take the heavy care and medical patient.	Tube feeders are a real problem. Nursing homes seem to have a quota for tube feeders. It is basically a result of their staffing. Nursing home ratio of staff to patients is such that they can't take the heavy care patients. Skin Problems/decubitus -- state licensure is so strict that nursing homes don't want these patients for fear of fines. Total care patients. This is a staffing issue -- nursing homes do not have enough staff.
Hospital G	Placing patients has eased somewhat in this county because of some additional beds added recently. One nursing home added beds and will take Medi-Cal and one built a new home but will only take private pay. This has eased the supply for private pay more than for Medi-Cal.	Decubitus -- nursing homes are expected to improve the decubitus they get, and it's hard to improve and they get fined. Mental illness -- the only facility is in Napa, and they don't have a lot of openings. Special needs such as trach care and Hickman catheter care. AIDs patients.

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital H	This is a small town geographically isolated with few Medi-Cal patients. Little or no competition from others hospitals. Fortunately, we have a distinct part SNF (since December 1986) that has helped with placement problems. She has just completed her own internal study and found that they don't really have a problem (just in the last year or so) with placements. And, in fact, she has stopped the report on administrative days because she really doesn't have any more.	The more care a patient requires the less the nursing homes want them. Patients with nutrition problems, extra feeding costs. Special feeding/nutritional supplies are a particular problem because Medi-Cal rates do not cover the extra costs. Heavy care patients -- e.g., ventilator patients, IV patients (although some nursing homes will take these). Patients who don't have any family — facilities are not staffed to provide extra attention, services such as renewal of Medi-Cal eligibility. Don't have the personnel to do these. Also need a responsible part to authorize treatment, get Medi-Cal renewed, Medi-Cal death expenses, processing required.
Hospital I	Most elderly we serve are either Medi-Cal or will be Medi-Cal shortly because nursing home costs are so high. Hospital has had problems placing Medi-Cal patients, particularly within San Francisco, because there are only limited Medi-Cal beds and too many hospitals competing for the limited supply. She has heard that nursing homes need a certain proportion of private pay patients who pay higher rates to meet their costs and make up the difference for the low rates under Medi-Cal. She says the nursing homes in the San Francisco area like to keep Medi-Cal at 10-20 percent. However, she travels to area nursing homes and develops relationships with their social workers and admit people. So when they do have a Medi-Cal bed available, they will call her directly. She goes to most homes that take Medi-Cal in the San Francisco area and into the East Bay and the Peninsula as well. She also has a reward system that is "in her own head" -- if a nursing home will take a difficult patient, then she will try to gear the family of a private pay patient to check with that facility. She will not work with nursing homes that take private pay only.	Heavy care patients — total feeding, NG tube. Diabetics — because of risk of skin breakdowns/insulin expense. Combative/yellers/confused (and if these are Medi-Cal patients, forget even trying to place them). IV therapies. Oxygen patients. Decubitus skin problems. Medi-Cal patients with no family members or responsible parties. This is because then there is no one to monitor Medi-Cal eligibility, to renew Medi-Cal, or if this person is tranferred to another county (which happens quite often in San Francisco) then the Medi-Cal must also be transferred which takes a lot of time. These tasks are generally handled by the family members, so if there is no family member then the nursing home social worker or hospital has to do it. The worst cases are the ventilator dependent patients or borderline subacute care patients. Only one facility in the area will take these patients and can handle only a few of these patients at any one time.

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital J	Placement does not seem to be too much of a problem. She thinks there is an adequate number of beds in this area. One in awhile she will have a patient awaiting placement but in general is able to place patients. They have two SNFs they use. One attached and one freestanding in the area.	Right now she is having trouble placing a 32 year old, 400 lb. patient who has cellulitus of the legs and sleep apnea. Nursing homes seem to have their own set of criteria about who they can and cannot take. She doesn't know exactly what they are, but they seem to be related to the level of care and staffing. They just don't have the staff to take heavy care patients.
Hospital K	In an effort to cut back, the hospital recently dissolved its social services staff and UR is now doing all discharge planning. He feels it is not so much the patient's condition but who pays. Medi-Cal rates are too low, no one wants them (including their own freestanding facility) so they end up on AD days in the hospital.	Nursing homes will not take Medi-Cal pending patients. It is impossible to place these patients without their Medi-Cal sticker. They have difficulty placing Medi-Cal "long-term" patients in general. Especially the heavy care: e.g., trach care, ventilators. The Medi-Cal rates are too low — they do not cover the costs of caring for those with heavy care needs. He also mentioned some difficulty in placing a Chinese patient whose family did not speak English. It just took longer to place and this patient also ended up on AD days in the hospital.
Hospital L	Although there has always been a placement problem, it has been getting increasingly worse. There are no Medi-Cal beds. One local nursing home recently dropped its Medi-Cal license because the rates are too low and they just make it financially. If the facility has only one empty bed they will hold out for one private patient. The MediCal field office has recently been looking at our patients in the DP/SNF and saying they no longer meet hospital-based SNF level care and thdat we have to place them in a freestanding facility. However, patients with IVs, complicated dressings, and ventilators need to be cared for in a DP unit, and not in a freestanding facility.	Medi-Cal only Heavy Care Ventilator dependent patients are impossible Oxygen Decubitus Obese Female patients--there are fewer female patients than there are male patients

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital M	No problem with Medi-Cal patients per say. Medi-Cal can be a problem for certain facilities but this seems to have eased up this over the last few years. Placement problems come from level of care not payer source, but it is always easier for private pay even over Medicare. Placement problems depend upon characteristic of patient care — the more they have wrong (e.g., NG tubes) the more difficult they are to place.	Oxygen -- facilities are not allowed to have tank set up in the room, so they feel they are not paid enough for the oxygen services. Skin problems such as decubitus ulcers require more nursing care; stage three care requires a licensed nurse. Nursing homes want only those that require nurses aide level care, plus state reviewers are tough on fines for skin conditions. Combative patients. If Haldol on the medication list they turn down the patient -- they don't want behavior problems.
Hospital N	Placement is a funding issue. There are enough beds available but they won't take the Medi-Cal. Total care Medi-Cal patients are hard to place. Total care private pay is not hard.	Hard to place include the non-Medicare patients like the head injury and ventilator patients. This is a new group of patients — need long period of respite to see if they will come out of coma. EX: 25 years old head injury. Here for two years finally one nursing home took this patient. — a nursing home in area trying to start a specialty in this area. If Medi-Cal then you are going to have difficulty — harder because the nursing homes are geared to the elderly and younger patients may require a different skill level. One patient who has been there for over a year -- NG tube, semicomatose, needs complete care. Came in for CVA. He was a crossover patient — Medi-Cal/Medicare. Medicare has run out- but his level of amount of care is too great. The area nursing homes have their quota of heavy care patients already and won't take him. The problem is that they can get lower levels of care patients at the same rate. The cost is too great.

Exhibit B-3

RESPONSES TO SELECTED QUESTIONS IN THE SURVEY OF HOSPITAL DISCHARGE PLANNERS:

HOSPITALS WITHOUT A HOSPITAL DISTINCT PART UNIT

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital O	She has been in Utilization Review for ten years and discharge planning for two years. Yes, they definitely have problems but have always had problems. It hasn't changed much over time.	Medi-Cal in general is difficult because rates are so low. Anyone on a maintenance respiratory. Total parenteral nutrition maintenance. Vegetative/comatose state. Mixed diagnosis -- those with psych as well as medical problems. Need both acute care services and psychiatric care (Napa State Hospital has a small wing for these patients but it is hard to get them in.) Brain syndrome. AIDs patients. Behavior problems.
Hospital P	Yes, we definitely have a problem placing patients. They have always had a problem — the situation has not changed significantly over time. Just have four facilities we use and have always had a problem, particularly for Medi-Cal patients.	Have particular problem with "long-term placements." These are difficult because most will become Medi-Cal patients and Medi-Cal nursing home rates are so low that nursing homes do not want them.
Hospital Q	Yes, we have trouble and it has gotten worse. Particularly since DRGs. Medicare made provisions for paying hospitals but they did not make provisions to pay SNFs, so the SNFs just are not taking the heavy care patients. Patients going home with home health care are sicker than those going to nursing homes, even though licensed as a SNF they will not take many skilled level patients. She thinks that there is a law that prevents a SNF from taking patients with IVs. She said the SNFs can't take them so we send patients home on IVs. She has sent patients home with huge wounds almost to the bone, colostomies, patients who are senile and can't care for themselves. Nursing homes won't take these patients for fear of fines for deficiencies.	Feeding tubes. Colostomy. Decubitus. Obese patients. Total care. NG tubes.

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital R	She was so glad that someone in Sacramento was finally looking into this issue — that someone cares enough to call and ask some questions about the problems we are having. We definitely do have problems and it has gotten worse -- patients are discharged sicker and there are not enough beds to receive them. Pressure from DRGs and from Medi-Cal to get patients out.	A Medi-Cal patient with a trach is impossible — nursing homes simply won't take them. Too much nursing care and too little reimbursement -- they get the same amount of reimbursement whether the patient is total care or whether they can walk around and take care of themselves. They can pick and choose the ones they want. Patients with either MR or a psychiatric diagnosis and medical problems. The big problem is that because there are no places for these dual problem patients to go they end up staying here. Many will come through the ER and then we're stuck and we can't place them.
Hospital S	For Medi-Cal patients the higher the level of care required the less money available to provide the care and the less willing the nursing home is to take those patients. The hardest to place are those with heavy care needs, particularly those with Medi-Cal as payment source. The other factor influencing placement is the bed shortage. Facilities don't want to fill their beds with heavy care patients when they know they can get a lighter care patient. Also the climate of the DRGs — patients are sicker coming into the hospital and sicker going out.	Any heavy care patients. Those that are bed bound, incontinent of bowel or bladder. Comatose patients; a comatose patient with a stomach tube for feeding is almost impossible. Feeding tubes or any tubes — the more tubes the more difficult it is to place. Patients under age 60; nursing homes don't want to take these patients because the population is older, and younger are more coherent, complain more, are more active; these patients take more staff time.
Hospital T	They do not have an access problem right now, but are concerned that the bed supply may tighten up. About a year ago there were more problems. But a new facility was built in this area that has helped a lot although those beds are filling up too. They have always been able to place patients in Ukia which is 30 miles away — four facilities there. Never have had problems placing patients there and still do placements about 1-2 times a month. Primarily because one home there will take patients with IV antibiotics and none of the nursing homes in this area will take them. One other home in Ukia is gearing up to take more of these patients.	Tube feeders — if the facility has five or six patients already they say they can't handle any more because of staff. AIDs is another big problem. Patients with combined acute needs and chronic alcohol problems. IV patients are difficult to place in town so all go to Ukia, 30 miles away. The problem of distance still exists for the family.

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital U	Yes! They do have problems placing Medi-Cal patients. They are a county hospital, so they have almost all Medi-Cal patients. It is getting harder and harder to place Medi-Cal patients. They usually have to place Medi-Cal patients in Los Angeles County. This is very stressful for family.	Nursing home patients that do not yet have Medi-Cal; they have to quickly get the Medi-Cal approved. Paraplegic. Decubitus patient (of any age). Trach patient. Brain damage/coma.
Hospital V	Definitely!!! The nursing homes usually have waiting lists for the Medi-Cal patients. Any Medi-Cal patient with heavy custodial care needs is difficult to place. Nursing homes say they can't staff up for these patients.	Stroke patients who are helpless, bed-bound, can't feed themselves, and who don't have any needs that Medicare will cover. Younger patients with head injury who are Medi-Cal only. Any long term patient needing care will be difficult to place. Patients without family. These patients cannot handle their affairs to be sure that the facility will get Medi-Cal payment. She can usually place these patients if she calls around the whole county, will usually find one home that will take these patients.
Hospital W	Yes! Any Medi-Cal patient. She used to be able to give families a choice, but now she has to work her list of who has a bed available. Facilities do "pick and choose." They all tell you that they have their fair share of Medi-Cal patients.	A decubitus patient, that is not bad enough to qualify for Medicare. Trach patient. Heavy care patient. Sometimes, a psychiatric elderly patient.

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital X	Yes, but it depends upon what kind of patient you are calling about. Particularly because they are a county facility, and do not have any contracts with nursing homes. In the last year, the placement situation has become much more difficult. Private hospitals are signing contracts with nursing homes to reserve beds and pay an additional $25 over the Medi-Cal rate. Many facilities that used to take her Medi-Cal patients no longer do. Also, the public guardianship office is at capacity, so they cannot process any cases quickly.	Patients who have Medicare coverage, do not qualify for Medicare skilled, no private funds, and now need to apply for Medi-Cal. You can't place these patients until you get a Medi-Cal number. Getting a Medi-Cal number can take anywhere from 1-2 days to 2 months. Medicare/Medi-Cal heavy care patients. Medi-Cal, heavy care patients are hard to place, such as NG tubes. Medi-Cal patients with dual diagnoses are hard to place. Younger Medi-Cal patients who have head injuries are hard to place. Nursing homes would prefer not to mix their populations (both young and old). They have no problem placing private pay patients.
Hospital Y	Yes. She definitely has problems finding nursing home placements for her patients, although she has an easier time than most other social workers in the hospital. She has been here for 18 years, so she remembers the time when nursing homes used to call her about patients. Those days are definitely over.	The following types of patients are practically <u>impossible</u> to place: o Ventilator o Tracheotomy o AIDs o TB (facilities won't take patients with TB even if they are on medications and considered non-infectious. They want to see three negative cultures.) These patients are <u>also difficult</u> to place: o Decubitus ulcer. o Dual diagnosis. o Total care patient with Medi-Cal only. o Any patient with a history of alcohol and drug abuse. o Younger patients, such as spinal cord injury (facilities hesitate to take younger patients because they have predominantly elderly patients, and they are afraid the patient won't fit in well.)

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital Z	She does have some problems placing patients. While she feels that it is becoming more difficult to place patients, she does not feel that it is impossible. However, they do not have a major problem with "administrative days" for patients in any payer category. Placement problems are seasonal -- bigger problem in the winter than in the summer. Her biggest problem is with "choice of facility." The homes closest to the hospital, where most of the physicians will visit, have waiting lists. Nevertheless, most of her placements are within a 10 mile radius of the hospital.	She has problems placing respirator patients. Most of these patients must to LA county, which is one hour away. Lack of ICF care in the community can sometimes be a problem. Some problems do arise. For example, all the convalescent hospitals (this a term for SNF) require a Medicare-only patient to make a $2000 deposit. I case Medicare doesn't pay, they use this money to pay the bill. Sometimes family cannot produce $2000 so instead they decide to take the person home with home care services. In the meantime, she'll apply for Medi-Cal in cas they later need to go to a nursing home.
Hospital AA	Yes, but she does think that there is a shortage of beds, but that they don't need any more facilities that will only take private pay or Medicare patients; not Medi-Cal patients. They need facilities that will take Medi-Cal patients immediately. Some facilities have waiting lists, some don't. It depends on the facility. Some facilities have waiting lists and won't take the names of Medi-Cal patients.	Heavy care patients -- totally bed-bound and unable to eat. Ventilator dependent but stable. Extremely confused patients who can no longer get around easily by themselv Patients with a history of psychological problems, but who are controlled o medications. Schizophrenia, manic depressive.
Hospital BB	Yes, they have a lot of problems placing patients. Since they are a county hospital, a lot of patients get dumped on them who are then very difficult to place. Nursing homes don't say they don't have a bed; they say they don't have a bed for a heavy care patient.	Decubitus ulcers. (Facilities feel liable when the licensing folks come by This makes their facility look bad to the inspectors, because the inspector don't know if the patient got the decubitus in the home or somewhere else.) NG tubes. Tracheotomies. Respirators. Patients with psychiatric overtones (for example, Alzheimers or other organi problems).

	Q.1: We are interested in whether you have problems placing patients in nursing homes.	Q.2: Which patients are the hardest to place and why?
Hospital CC	Medi-Cal patients are the most difficult to place.	Medi-Cal patients become progressively more difficult to place as their care needs increase. Patients who need feeding tubes (either NG or gastrostomy), physical therapy, and cannot ambulate are difficult to place. There is a problem with Medi-Cal reimbursement being so low, and the same rate for all Medi-Cal patients regardless of care needs. A patient with a decubitus ulcer is the hardest to place, especially if the patient has multiple decubiti. The state inspectors come down hard on the facilities if they have patients with decubitus. Most nursing homes don't have any RNs giving care, so they don't want patien who need skilled nursing, such as NG feedings.

Exhibit B-4

RANKING OF CATEGORIES OF PATIENTS BY DIFFICULTY OF PLACEMENT IN HOSPITALS WITH AND WITHOUT DISTINCT PART UNITS[1]

	RELATIVE RANKING BY HOSPITAL																			
	DISTINCT PART				$\bar{X}$	SD	NO DISTINCT PART										$\bar{X}$	SD	TOTAL	
CATEGORIES	#1	#2	#3	#4[2]			#5	#6	#7	#8	#9	#10	#11	#12	#13	#14			X	SD
Private Pay Light Care	1.0	1.0	1.0	1.0	1.0	0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0	1.0	0
Private Pay Heavy Care	1.5	3.0	1.5	100	2.0	0.9	5.0	4.0	2.0	1.2	2.0	1.3	1.1	4.0	2.0	1.5	2.3	1.2	2.4	1.4
Medi-Cal Pending Light Care	5.0	8.0	3.5	Off Scale	5.5	2.3	100	10.0	Off Scale	Off Scale	5.0	4.0	Off Scale	15.0	Off Scale	5.0	17.3	31.2	23.2	37.9
Medi-Cal Pending Heavy Care	7.0	8.0	5.0	Off Scale	6.7	1.5	Off Scale	10.0	Off Scale	Off Scale	10.0	8.0	Off Scale	40.0	Off Scale	10.0	12.3	11.4	15.6	13.7
Medi/Medi Light Care	N/A	3.5	1.5	10	2.5	1.4	1.0	3.0	2.0	1.5	10.0	1.5	3.0	2.0	1.0	5.0	2.9	2.5	3.0	2.7
Medi/Medi Heavy Care	N/A	4.0	2.0	100	3.0	1.4	10.0	3.0	3.0	1.3	1.5	3.0	2.0	5.0	10.0	3.5	4.0	3.0	4.2	3.2
Medi-Cal Light Care	5.0	3.5	2.0	1.0	3.5	1.5	1.5	6.0	2.0	1.5	1.5	1.5	3.0	20.0	1.0	5.0	4.1	5.0	4.3	5.8
Medi-Cal Heavy Care	7.0	5.0	2.5	100	4.8	2.3	12.5	8.0	3.0	5.0	10.0	4.0	6.0	40.0	100.0	10.0	16.4	26.9	19.9	30.1

[1] Information obtained in response to a question requesting relative ranking of patients by difficulty/ease of placement.

[2] Not included in calculations.

INTERVIEW GUIDE FOR DISCHARGE PLANNERS

1. First, we are interested in knowing whether you have problems placing patients.

2. Which patients are the hardest to place and why? Please give specific examples and describe care needs.

3. How have the number of homes and the length of waiting lists changed over time? Do you feel additional beds are needed? If so, what type (SNF, ICF, other)?

4. About how many patients are you trying to place on a monthly basis?

5. How many of these patients are difficult to place and become "backed up" in hospitals awaiting placement?

6. What is the ALOS for patients "awaiting placement"? (from the time when they are determined to be no longer in need of acute care to the time when they are placed)

7. Who are the payers for "awaiting placement"? (skilled and custodial)

8. What is the longest time any one patient stayed "awaiting placement?" Describe this patient.

9. How do you go about placing nursing home patients?

   - How do you find out if there is a bed available?
   - How many SNFs and ICFs do you regularly use?
   - Does the state have any specific guidelines on how far or who you can place outside of your immediate area?

10. How do nursing homes get involved in the process of selecting patients?

11. Does your hospital have any special arrangements with nursing homes to reserve beds or services?

12. Ranking of patients by payer class and care needs. Private pay light care patients are a 10 on this scale. Please rank each category of patient by relative difficulty or ease of placement.

    Private pay light care **10**

Private pay heavy care
Medi-Cal pending light care
Medi-Cal pending heavy care
Medi-Medi light care
Medi-Medi heavy care
Medi-Cal light care
Medi-Cal heavy care

13. Additional comments:

B. DISTINCT PART UNIT QUESTIONS

For hospitals with no distinct part unit;

1. Does your hospital have plans to build a distinct part skilled nursing facility? Why or why not?

For hospitals with distinct part units;

1. When did your distinct part unit open and what were the circumstances that led to its development?

2. How do you go about placing a patient in your distinct part unit (describe discharge planning process)?

   - What type of patient is generally placed in the hospital SNF? Which ones are referred out? How do you decide?

3. What criteria does the Medi-Cal field office use to determine whether a patient qualifies for payment in a hospital-based SNF as opposed to a freestanding?

4. Do you get patients directly from the community?

   a. If yes, about what percent of your distinct part patients come from the community?

   b. Are these patients different (diagnosis, prognosis, payer source, etc.) than the patients admitted directly from the hospital?

5. Since you opened your distinct part unit, have you had any problems with the freestanding nursing homes in your area, for example, those homes with whom you had past relationships?

6. Additional comments:

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps